

THE  
**MEDICAL JOURNAL**  
OF AUSTRALIA

VOL. II.—11TH YEAR.

SYDNEY: SATURDAY, NOVEMBER 1, 1924.

No. 18.

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## Table of Contents

ORIGINAL ARTICLES—	PAGE.	CORRESPONDENCE—	PAGE.
"The Duties and Responsibilities of the General Practitioner in Regard to Infectious Diseases," by W. G. ARMSTRONG, M.B., Ch.M., D.P.H. . . . .	463	Malignant Disease of the Uterus . . . . .	486
"Radium in the Treatment of Rodent Ulcers at Sydney Hospital," by LANGLOH JOHNSTON, M.B., Ch.M. . . . .	467	Causes of Depopulation Among Some Island People . . . . .	486
"A Peep into the Past: Early Australian Surgery," by NORMAN J. DUNLOP, B.A., B.Sc., M.B., Ch.M. . . . .	471	The Preparation of "Carbonic Snow" . . . . .	486
REVIEWS—		Specialists and the Gentle Art of Money Making: Get-Rich-Quick-Wallingford has Compeers . . . . .	486
Malaria . . . . .	476	Puerperal Mortality . . . . .	487
LEADING ARTICLES—		OBITUARY—	
The Right of Reply . . . . .	477	John Steell . . . . .	487
CURRENT COMMENT—		William Henry Semple . . . . .	487
Duodenal Drainage and the Biliary Tract . . . . .	478	George Henry Gibson . . . . .	487
ABSTRACTS FROM CURRENT MEDICAL LITERATURE—		ANDERSON STUART RESEARCH MEMORIAL FUND . . . . .	487
Ophthalmology . . . . .	480	UNIVERSITY INTELLIGENCE—	
Laryngology and Otology . . . . .	481	The University of Sydney . . . . .	487
BRITISH MEDICAL ASSOCIATION NEWS—		CONGRESS NOTES—	
Scientific . . . . .	482	International Congress of Radiology . . . . .	488
Nominations and Elections . . . . .	485	BOOKS RECEIVED . . . . .	488
POST-GRADUATE WORK—		MEDICAL APPOINTMENTS . . . . .	488
November Course in Melbourne . . . . .	485	MEDICAL APPOINTMENTS VACANT, ETC. . . . .	488
		MEDICAL APPOINTMENTS: IMPORTANT NOTICE . . . . .	488
		DIARY FOR THE MONTH . . . . .	488
		EDITORIAL NOTICES . . . . .	488

### THE DUTIES AND RESPONSIBILITIES OF THE GENERAL PRACTITIONER IN REGARD TO INFECTIOUS DISEASES.<sup>1</sup>

By W. G. ARMSTRONG, M.B., Ch.M. (Sydney),  
D.P.H. (Cantab.),  
Sydney.

THE legal duties directly imposed on medical practitioners by the *Public Health Acts* of this State in relation to infectious disease are few in number and consist in the main of compulsory notification of certain specified diseases to the proper authorities. The object of notification is to enable the authorities and in the case of school children the teacher to enforce the necessary precautions to prevent the spread of infection. Indirectly, however, certain responsibilities are thrown by implication upon practitioners owing to their professional relationship as advisers to their patients which it would be unwise to overlook.

The list of notifiable infectious diseases in New South Wales, though not a short one, is at present less comprehensive than that in England and in most of the other Australian States, but it may be added to from time to time by proclamation if such action appears to be desirable either as a temporary expedient

or permanently. The diseases notifiable at present in addition to small-pox, leprosy and venereal disease are plague, scarlet fever, diphtheria, typhoid and paratyphoid fevers, infantile paralysis, cerebro-spinal meningitis and pulmonary tuberculosis, the last named being only notifiable in the Metropolitan and Newcastle areas, and in the tourist districts of the Blue Mountains.

The method of notification is that known as dual, both the medical practitioner and the householder being required to notify. In practice, however, dual notification has fallen into disuse and is now a dead letter both here and in England. Notification by the householder is only insisted on in practice where no medical practitioner has been in attendance. The householder, however, is legally responsible for notification jointly with the medical attendant and in one or two instances when medical notification has failed, both the medical practitioner and the householder have been prosecuted successfully by local authorities.

A legal opinion has been given to the effect that in the event of more than one practitioner being in attendance on a patient with infectious disease, each practitioner is legally required to notify. It has, however, never been the custom of the Health Department to insist on more than one notification for each case, except in relation to pulmonary consumption.

<sup>1</sup> Read at a meeting of the New South Wales Branch of the British Medical Association on August 28, 1924.



During my term at the Department of Public Health occasional inquiries used to be made by medical practitioners as to whether in the case of say diphtheria or typhoid fever notifications should be made upon clinical observations only or whether bacteriological confirmations should be awaited. They were informed that there was no necessity to delay notification for bacteriological confirmation nor indeed was it advisable to do so, as the consequent delay might under certain circumstances give time for a serious outbreak of disease to develop, which might have been checked by prompt action, had information of the first case been received early by the authorities.

A decision of the English Local Government Board supports this view, inasmuch as it lays down the dictum that the clinical opinion of a medical practitioner in charge of a case should not be set aside without his consent on the ground of a "negative" result yielded by a bacteriological examination. The right course in the public interest points to the notification of a case of infectious disease as soon as clinical observation warrants it. If later on it may seem advisable to the medical practitioner to withdraw the notification, that course is open to him and is not infrequently followed.

Stress must be laid upon the importance of prompt notification. The *Public Health Act* requires that it shall be performed "forthwith as soon as the medical practitioner becomes aware that the patient is suffering from a notifiable disease" and indeed it is evident that, if notification is to have any preventive effect, it must be done without unnecessary delay. Instances are not lacking—more particularly in case of infections spread by milk—where a little more promptitude in notification might have saved a smart outbreak of disease.

The notification of pulmonary tuberculosis is not at present general throughout New South Wales. It is only legally enforced in the Metropolitan and Hunter River (Newcastle) districts where the density of population is greatest and in the Blue Mountains health resorts. Within these three areas any medical practitioner attending a person suffering from pulmonary tuberculosis must take steps to ascertain if his sputum contains tubercle bacilli and if he has reasonable grounds for believing that such is the fact, he must report the case confidentially to the Medical Officers of Health in Sydney and Newcastle respectively and in the Blue Mountains to the Secretary of the Board of Health. If the medical attendant does not desire the patient to be visited by the departmental officers, he need only indicate the wish upon the notification form and it will be respected, but in that case he must undertake to inform the patient or his friends that the proper authorities must be notified if the patient changes his address. He must also undertake to instruct the patient in the precautions he must take to avoid spreading infection.

The question of disinfection of goods and premises after the occurrence of infectious disease is one of interest for medical practitioners not only on general grounds, but also because a medical practitioner's certificate of disinfection is sometimes

asked for by local authorities and it becomes necessary for him to assume the responsibility of certifying to the efficacy of the methods employed. There has been a great advance during recent years in our knowledge of the manner in which the various infections are propagated. Twenty years ago the agency of inanimate objects as the vehicles of infection was held to be paramount and as much or more care was taken in the disinfection of houses and their contents and of patients' clothing as in the prevention of the passage of infection from person to person. During the past twenty years the tendency has been gradually to modify our views of the frequency of the conveyance of infection by inanimate objects and to give increasing attention to the possibilities of transference by contact with the person and by the agency of insects and articles of food. This does not mean to say that the disinfection of the house and clothing after an attack of infectious disease has been given up. It has not, either in Australia or in most European countries. But in many American cities which have been perhaps over-eager to translate into practice the new knowledge before it has altogether passed from the realms of conjecture into those of certainty, the disinfection of houses and clothing after infectious disease has been altogether discontinued and replaced by ordinary domestic cleansing.

A tendency in the same direction is appearing in some English towns. In a recent article in *The Lancet*, Dr. Duncan Forbes, Medical Officer of Health for Brighton (England), presents a case for the simplification of the process of disinfection of dwellings after scarlet fever and diphtheria. He regards the present accepted methods as unnecessarily elaborate. He argues that the spraying of the walls of rooms in particular and the employment of steam disinfection of mattresses and similar bulky articles are unnecessary and points out that these processes have been omitted in Brighton for some years with statistical results which on the small figures available are better than those experienced previously under much more elaborate municipal disinfection. In short, in respect of these two diseases at least, Brighton relies—and according to its Medical Officer of Health not in vain—upon thorough domestic cleansing carried out by the householder and supplemented by the boiling of such clothing, bedding and drinking and eating vessels as have come into intimate contact with the patient.

My own feeling is that we are not justified in altogether forswearing the use of chemical disinfectants until we have more experience to guide us.

It is certain that the infection of some diseases attaches to clothes and other inanimate objects for longer and shorter periods of time and a medical practitioner would probably suffer considerably in reputation if he were to advise a client that he could take his children with safety into a house which had just been vacated by a consumptive patient without previous disinfection. I would class anthrax, tetanus, small-pox and tuberculosis as con-



stituting a group of infections which are more difficult to eradicate from fomites than most of the others. Anthrax is, as we all know, extraordinarily difficult to get rid of. Its spores will even stand boiling and may retain their vitality for years and though this is not true of tuberculosis and small-pox, the infectivity of these diseases is apparently persistent in clothing for an uncertain period. Rickards, Slack and Arms who carried out a series of careful tests in Boston by exposing tuberculous sputum on wood and cloth in the rooms of ordinary tenements, found that when dry and kept in diffused light, tubercle bacilli live about thirty days and in dark and dry rooms up to eighty-five days. Small-pox is probably less resistant. Rosenau is of opinion that further work upon the viability of the tubercle bacillus outside the body may further limit our views upon its powers of resistance.

Professor H. R. Kenwood in an address to the Congress of Medical Officers of Health at Hull last year summed up his views of the question in these words: "We may be justified in concluding that the bulk of infection spreads from individual to individual by direct contact and that most bacteria quickly lose their vitality on fomites and room surfaces, yet we cannot say that this is true of all infection. There is scientific justification for the view that thorough disinfection should materially reduce the risks of infection." This is the view still officially held here. The pamphlet on infectious diseases issued by the New South Wales Department of Public Health, while indicating that thorough cleansing in the usual household sense is the most important part of disinfection, also advises the use of chemical disinfectants and detailed instructions for the use of these are given in that publication. In the metropolitan area and in many of the larger country towns the municipal authorities undertake the disinfection of dwellings and their contents through the agency of trained disinfecting staffs and where this is the case, the work is best entrusted to them.

It is becoming more and more certain, however, that in most cases infectious disease is conveyed directly from person to person or by such close indirect contact as is implied in the use of common towels or drinking vessels and there are strong reasons for the belief that the "carrier" is a frequent agent of its spread.

The recent regulations issued at the instance of the Board of Health under the *Public Health (Amendment) Act 1921*, fully recognize the importance of carriers and prescribe new procedures to be followed for the prevention of the spread of infection, especially in schools. In these regulations the carrier is defined as "any person having in his nose or throat or in his excretions or discharges germs of any infectious disease, although presenting no signs or symptoms of the disease. Proof of the presence of such germs of disease to be established by bacteriological examination in a laboratory approved by the Director-General of Public Health." "Contacts" are defined as "persons who have been exposed to infection from any of the scheduled in-

fectious diseases" and they continue to be contacts until the completion of the prescribed period of incubation for each disease. For the purpose of this regulation the prescribed incubation periods of diphtheria, scarlet fever, epidemic cerebro-spinal fever and bubonic plague are in each case ten days and for infantile paralysis, small-pox and typhoid fever (including para-typhoid fever) each twenty-one days.

"Contacts" and "carriers" must submit to medical examination as required by a medical practitioner specially authorized by the Director-General of Public Health and must carry out his instructions. They may be placed under medical surveillance and isolated in their own homes or elsewhere if such action is deemed necessary to prevent the spread of infection.

It is to be noted here that no legal powers exist in New South Wales for the compulsory removal to hospital of persons suffering from infectious disease except in the case of small-pox, plague or cholera, on the appearance of which diseases the Government on the advice of the Board of Health may proclaim an infected area and the Board may thereupon take such steps to isolate any person in that area as it may consider necessary.

The regulations further provide that children with diphtheria are to be excluded from school for at least three weeks from the onset of illness; and for an additional four weeks, unless a medical certificate of freedom from infection is obtained. In scarlet fever the period of exclusion is at least six weeks and further until the child is free from obvious desquamation and aural and nasal discharges. In typhoid fever the period of exclusion is eight weeks or until receipt of a medical certificate of freedom from infection. Children who suffer from cerebro-spinal fever, infantile paralysis, bubonic plague or small-pox, cannot return to school without a medical certificate of freedom from infection. In the case of children who have not themselves suffered from infectious diseases, but have become contacts, the period of exclusion from school is based upon the scheduled incubation period of each disease with reference to the last exposure to infection, but contacts of patients with typhoid fever and leprosy are not excluded from school at all unless a medical practitioner certifies in writing that such exclusion is advisable to prevent the spread of infection and contacts of a patient suffering from infantile paralysis are only excluded for twenty-one days after paralysis first appears in the patient. Contacts of plague are readmitted to school as soon as the dwelling where they reside, is released from quarantine.

Already this evening I have made more than one reference to "carriers" of infectious disease and have read you the legal definition of a "carrier." The demonstration that many persons are carriers has thrown a new light upon the control of infectious diseases and is of such importance in relation to the subject we are discussing that a very brief résumé of the views now held may not be out of place.



Provisionally and for practical purposes carriers may be classified into four groups:

- (i.) The incubation carrier;
- (ii.) The contact carrier;
- (iii.) The convalescent carrier and
- (iv.) The chronic carrier.

The incubation carrier is a person who is in the incubation stage of an infectious disease and is able to infect other people. The evidence as to the occurrence of such a condition, though reliable, is scanty and probably the spread of disease by incubation carriers is uncommon, but logically one feels that it must occur sometimes. Once the individual has been infected, the infecting organisms must be multiplying somewhere either in his nasopharynx or his alimentary canal and there appears to be no reason why they should not be extruded and invade other individuals under favourable conditions. I have investigated outbreaks of typhoid fever in which the evidence seemed to point to the infection of some individuals by others who were in the incubation stage. Recently in the Straits Settlements three persons are recorded by Dr. W. Fletcher to have accidentally swallowed paratyphoid cultures. All three began to discharge paratyphoid bacilli in their stools a few days later and subsequently two of them became ill with paratyphoid fever.

Contact carriers are generally considered to be persons who are perfectly healthy and have not at any time suffered from the disease, the organisms of which they "carry." They have, however, been in contact with patients and have received infection from the latter. Owing to these persons' natural immunity the organisms have not been able to invade their tissues, but lodge and multiply upon the surface, so to speak, in the case of the nasopharyngeal affections and in the intestinal canal in the enteric group of diseases, without in either case doing any damage to their hosts. I do not feel satisfied that this concept of the contact carrier is correct in all cases. It seems likely that in some instances at least the contact carrier has really suffered from an extraordinarily mild attack of the disease which has escaped notice. However, the distinction is one which has little practical significance and need not be elaborated.

The convalescent carrier is a recovered patient who continues to throw off micro-organisms for a few days or weeks after he has recovered from his illness. If the convalescent or contact carrier remains infectious for a period usually arbitrarily fixed at three months, he is said to be a "chronic carrier." The convalescent carrier is responsible for "return" cases of infectious disease when patients who have been discharged from fever hospitals after complete recovery, infect another person in their home circle. The chronic carrier is often the cause of a fresh epidemic as well as of the sporadic cases which we so often see and are puzzled to account for. The chronic carrier may continue to be a carrier for many years. In the case of typhoid fever, instances of a carrier continuing to carry for many years are far from few

and I have personally known of diphtheria carriers of over three years' standing. Probably the most widely known and quoted case on record is that of a woman who was a professional cook in New York and became known as "Typhoid Mary." Between 1901 and 1915 it was ascertained that she infected at least fifty-seven persons residing in various localities in three different States of the Union.

While ample evidence has accumulated that carriers are able to infect with virulent disease persons with whom they come in contact, it is also true that very large numbers of carriers move freely about their business among the public for long periods of time, without any suspicion arising that they have caused attacks of disease in other persons. Though this fact may in some cases be due to want of opportunity for passing on the infective principle, it seems probable that in the majority of instances it is accounted for either by attenuated infectivity of the parasites in the carrier or to heightened resistance to infection on the part of those persons with whom he comes in contact. We have evidence of both the latter phenomena in the case of diphtheria. Every bacteriologist knows that organisms are sometimes recovered from throat swabbings which the most skilled observer is unable to differentiate from virulent Klebs-Loeffler bacilli, but which on submitting them to the ultimate test of passage through a guinea pig prove to be non-virulent. On the other hand the investigations of Schick and others who have worked in the same field, have shown conclusively that very large numbers even among young children are immune to the diphtheria bacillus, the proportion of immune individuals increasing with increasing age. In the case of typhoid fever and other intestinal infections the carrier's opportunities of passing on infection would appear to be fewer than in the case of those diseases in which infection lodges in and is given off from the cavities of the mouth and nose. In the former group of diseases it must be chiefly such carriers as are engaged in handling foods, who are dangerous.

In relation to typhoid fever carriers one must remember that intermittent excretion is not uncommon. Arkwright and Ledingham observed intervals ranging from days to months in which chronic carriers' faeces were free from bacilli, though they subsequently resumed excretion of them, and F. S. Dudley mentions a carrier whose faeces were found to be free from organisms in ten examinations out of eighteen. Women are more likely to become chronic typhoid carriers than men. Charles Simon ("Human Infection Carriers") states that fully 82% of all chronic "carriers" are females. This is particularly important in view of their intimate association with the preparation and handling of food. The blood of typhoid carriers generally yields a positive Weidal reaction. There are however, exceptions. I remember coming across one myself some years ago in a typhoid carrier in the Walcha district.

Next to typhoid fever, diphtheria is the disease in relation to which carriers are of most practical interest to medical practitioners in Australia. In



almost every outbreak of diphtheria the numbers of carriers are very great. Anyone who has had experience of trying to get rid of diphtheria from a school by the method of swabbing all throats and isolating those children found to harbour the Klebs-Loeffler bacillus, knows what a heart-breaking job it sometimes is. One may isolate every discovered carrier and a few days later find fresh ones whose throats at the first swabbing had not harboured bacilli. This will be repeated over and over again, until suddenly the outbreak at that particular school ceases. This used to be a most puzzling phenomenon until the discoveries of Schick gave the key to it. He found that all children are not liable to contract diphtheria. A large number are naturally immune and cannot contract it. The proportion of such naturally immune children steadily increases with increasing age. Only 30% of children at one year of age are immune, while at ten years this proportion has increased to about 75% and becomes much greater still at later ages. In any average school population then the majority of the children are free from the risk of diphtheria themselves, though they may become carriers and infect others. Fortunately Schick was able to establish a satisfactory inoculation test which on being applied to any child will indicate whether he is immune or otherwise. If not immune naturally, artificial immunity lasting for years can be conferred by inoculation with a standardized mixture of diphtheria toxin and antitoxin. Very satisfactory results have been recorded in America of the practical value of this method. A beginning has been made in the use of the method here by the Department of Public Health and it seems probable that in the future the preventive treatment of diphtheria will be on these lines, which appear to promise far more than anything we have been able to achieve hitherto.

Carriers are known to occur in connexion with many other diseases and give rise to problems which are as yet for the most part unsolved. Medical treatment including the administration of antitoxins and vaccines, has little effect upon their condition. The question of their quarantine and control also presents many difficulties.

Convalescent carriers are, as a rule, easily dealt with. In cases of diphtheria the patient should not be allowed out of hospital or other isolation, until on at least two occasions no bacilli have been recovered from his throat and nostrils and all abnormal discharges from the nose or ears have ceased. In epidemic times when every bed in the isolation wards is urgently needed, this may be an impossible ideal to reach, but under such conditions the friends should be warned of the infectivity of the convalescent when he is sent out of hospital, with a view to his isolation at home. It seems right also that the faeces and urine of typhoid fever convalescents should be examined as a matter of routine before they are discharged from hospital. It is when we come to the chronic carrier that difficulties arise. The strict quarantine of all chronic carriers of typhoid and para-typhoid fevers and diphtheria would be impracticable and fortunately is unnecessary. As far as the enteric group is concerned, the problem of the chronic carrier is one

which can be largely solved by preventing the carrier from handling food-stuffs. The typhoid carrier is dangerous to others chiefly through his contact with food-stuffs. In the case of the chronic diphtheria carrier the *desideratum* is to keep him as far as possible from contact with children, who are far more susceptible to infection than adults. Fortunately typhoid fever is rarely "carried" by children though diphtheria very frequently is.

#### RADIUM IN THE TREATMENT OF RODENT ULCERS AT SYDNEY HOSPITAL.<sup>1</sup>

By LANGLOH JOHNSTON, M.B., Ch.M.,  
Honorary Physician for Diseases of the Skin,  
Sydney Hospital and Saint Vincent's  
Hospital.

Radium has now been used at Sydney Hospital since 1911 and during that period about two thousand patients with rodent ulcer have been treated and of these 90% have been absolutely cured. Rodent ulcers react admirably in the direction of cure under the influence of radium.

They are all capable of healing by simple modification without any ulcerative, crusted-on severe stage of reaction. In the cases under review the results were obtained by a combination of the selective or specific action with the inflammatory reaction of radium.

Radium is of special value in the treatment of rodent ulcers, as with few exceptions they all occur on the face; the æsthetic value of the scar is of the greatest importance, absence of retraction, depression and prominent bands is the rule and this is a great advantage in the treatment of ulcers in the neighbourhood of orifices, especially those situated on the eyelids. The scars are usually smooth and supple and after a few months can hardly be distinguished from the neighbouring healthy tissue. Convenience of application, absence of all constraint and freedom from pain are all great advantages in the treatment of these lesions which in the vast majority of cases occur in old people. The shape of the apparatus can be adapted to the regions to be treated.

All the patients shown were treated over ten years ago, so we can speak with authority on the permanency of the cure.

#### Legends to Illustrations.

##### PATIENT I.

Figure I.—Fungating epithelioma of the right parotid region of five months' duration in patient, aged sixty-three years.

Figure II.—Six weeks after treatment.

Figure III.—Two months after treatment.

Figure IV.—Ten weeks after treatment.

Figure V.—Three months after treatment.

The apparatus used for Patient I. consisted of a rectangular plaque, on which the radium was spread, containing one hundred milligrammes of radium of a radio-activity of 1,000,000. It was applied for thirty hours with a one millimetre nickel screen to each of the seven spots.

##### PATIENT II.

Fungating epithelioma, right temporal region of two years' duration, has grown very rapidly during last few months.

Figure VII.—Stage during treatment.

Figure VIII.—Stage during treatment.

Figure IX.—Stage during treatment.

Figure X.—Final stage.

<sup>1</sup>Based on a demonstration given at a meeting of the New South Wales Branch of the British Medical Association on July 10, 1924.



## ILLUSTRATIONS TO DR. LANGLOH JOHNSTON'S ARTICLE.



FIGURE I.—PATIENT I.



FIGURE VI.—PATIENT II.



FIGURE XI.—PATIENT III.



FIGURE XII.—PATIENT III.



FIGURE II.—PATIENT I.



FIGURE VII.—PATIENT II.

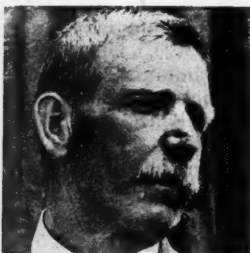


FIGURE XIII.—PATIENT IV.

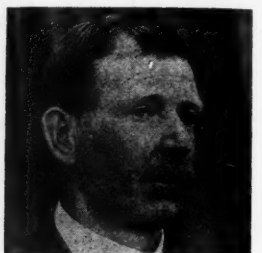


FIGURE XIV.—PATIENT IV.



FIGURE III.—PATIENT I.



FIGURE VIII.—PATIENT II.



FIGURE XVI.—PATIENT V.

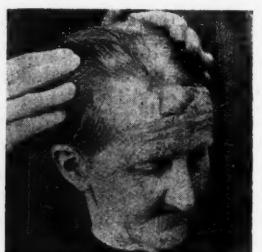


FIGURE XV.—PATIENT V.

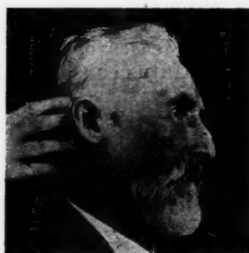


FIGURE IV.—PATIENT I.



FIGURE IX.—PATIENT II.



FIGURE XVIII.—PATIENT VI.



FIGURE XVII.—PATIENT VI.

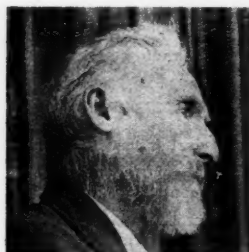


FIGURE V.—PATIENT I.



FIGURE X.—PATIENT II.

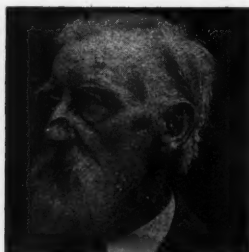


FIGURE XIX.—PATIENT VII.

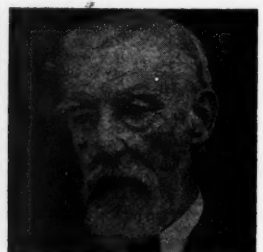


FIGURE XX.—PATIENT VII.



ILLUSTRATIONS TO DR. LANGLOH JOHNSTON'S ARTICLE.

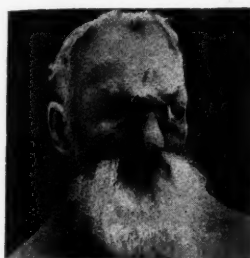


FIGURE XXI.—PATIENT VIII.



FIGURE XXII.—PATIENT VIII.

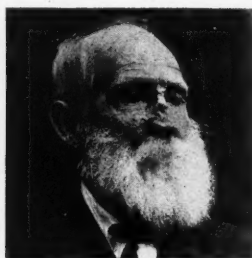


FIGURE XXIII.—PATIENT IX.

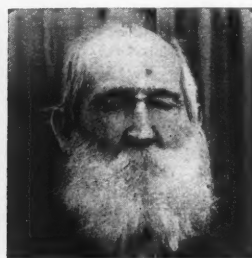


FIGURE XXIV.—PATIENT IX.

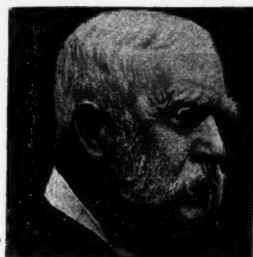


FIGURE XXV.—PATIENT X.

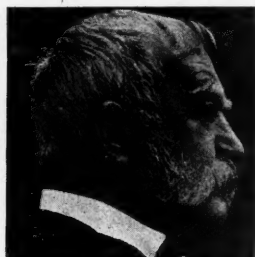


FIGURE XXVI.—PATIENT X.

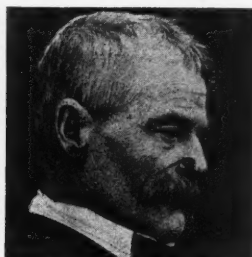


FIGURE XXVII.—PATIENT XI.

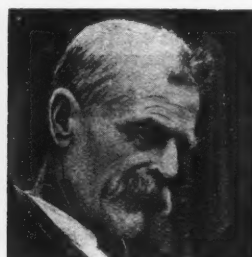


FIGURE XXVIII.—PATIENT XI.

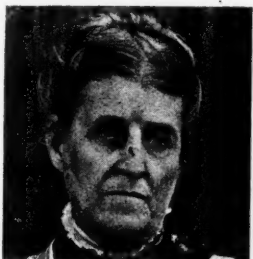


FIGURE XXIX.—PATIENT XII.



FIGURE XXX.—PATIENT XII.

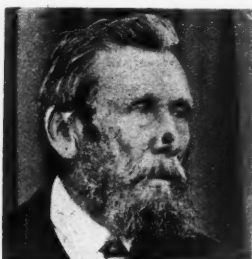


FIGURE XXXI.—PATIENT XIII.

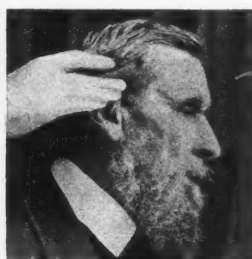


FIGURE XXXII.—PATIENT XIII.



FIGURE XXXIII.—PATIENT XIV.



FIGURE XXXIV.—PATIENT XIV.

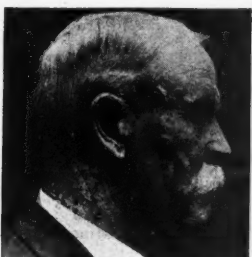


FIGURE XXXV.—PATIENT XV.



FIGURE XXXVI.—PATIENT XV.



FIGURE XXXVII.—PATIENT XVI.



FIGURE XXXVIII.—PATIENT XVI.



FIGURE XXXIX.—PATIENT XVII.



FIGURE XL.—PATIENT XVII.



## ILLUSTRATIONS TO DR. LANGLOH JOHNSTON'S ARTICLE.



FIGURE XLI.—PATIENT XVIII.



FIGURE XLII.—PATIENT XVIII.



FIGURE XLIII.—PATIENT XIX.



FIGURE XLIV.—PATIENT XIX.



FIGURE XLV.—PATIENT XX.



FIGURE XLVI.—PATIENT XX.



FIGURE XLVII.—PATIENT XXI.

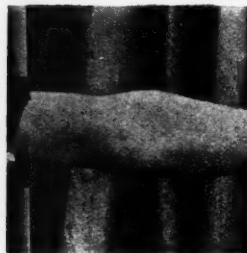


FIGURE XLVIII.—PATIENT XXI.



FIGURE XLIX.—PATIENT XXII.



FIGURE L.—PATIENT XXII.



FIGURE LI.—PATIENT XXIII.



FIGURE LII.—PATIENT XXIII.

## PATIENT III.

Figure XI.—Epithelioma of chin of eighteen months' duration; onset from pulling out the hairs on the skin, in patient aged sixty-three years.

Figure XII.—Final result.

## PATIENT IV.

Figure XIII.—Rodent ulcer, right *ala nasi* of three years' duration in patient aged forty-three years.

Figure XIV.—Final result three months after treatment.

## PATIENT V.

Figure XV.—Superficial cicatrizing type of rodent ulcer of six years' duration (five centimetres square) in patient aged seventy-six years.

Figure XVI.—Final result.

## PATIENT VI.

Figure XVII.—Post-operative recurrent rodent ulcer of left ear of twenty-seven years' duration in patient aged fifty-two years.

Figure XVIII.—Final result.

## PATIENT VII.

Figure XIX.—Rodent ulcer of the left side of the nose of twelve months' duration in patient aged sixty-seven years.

Radium plaque containing sixty milligrammes of radium of a radio-activity of 1,000,000 was applied for twenty-four hours with a 0.3 millimetre nickel screen.

Figure XX.—Result when patient was seen again four months after final application of radium.

## PATIENT VIII.

Figure XXI.—Fungating epithelioma of two years' duration in patient aged seventy-nine years.

Figure XXII.—Result three months later.

## PATIENT IX.

Figure XXIII.—Rodent ulcer of nose.

Figure XXIV.—Three months after final application.

## PATIENT X.

Figure XXV.—Rodent ulcer on right cheek of eight months' duration in patient aged seventy-three years (not well shown on account of the reduction in size of the picture).

Figure XXVI.—Two months after treatment (result not well shown).

## PATIENT XI.

Figure XXVII.—Rodent ulcer involving right *ala nasi* of fifteen years' duration. He was operated on twice unsuccessfully. The last operation was two years before the application of radium treatment.

Figure XXVIII.—Two months after treatment.

## PATIENT XII.

Figure XXIX.—Rodent ulcer on the right side of the nose of twelve months' duration in patient aged fifty-two years.

Figure XXX.—Result two months after treatment.

## PATIENT XIII.

Figure XXXI.—Rodent ulcer on the right side of the nose of one year's duration; size nineteen by thirteen millimetres, in patient aged seventy-eight years.

Figure XXXII.—Three months after final application.

## PATIENT XIV.

Figure XXXIV.—Two months after final application of radium.

## PATIENT XV.

Figure XXXV.—Rodent ulcer of four years' duration in the right temporal region. Onset as a keratosis. The patient's face and neck are covered with senile lentigines.

Figure XXXVI.—Second photograph taken two months after showing pigmented scar.



## PATIENT XVI.

Figure XXXVII.—Rodent ulcer of the right *ala nasi* of eighteen months' duration in patient aged forty-three years.

Figure XXXVIII.—Result two months after treatment.

## PATIENT XVII.

Figure XXXIX.—Rodent ulcer of the left cheek of eight months' duration.

Figure XL.—Result four months after treatment.

## PATIENT XVIII.

Figure XLI.—Rodent ulcer of two years' duration below left lower lid.

Figure XLII.—Result two months after treatment.

## PATIENT XIX.

Figure XLIII.—Spring catarrh affecting ocular conjunctiva of sixteen years' duration in youth aged eighteen years. The patient was sent by Dr. Gordon Macleod.

Figure XLIV.—Result two years after treatment.

## PATIENT XX.

Figure XLV.—Verruca *neurogenica* (tuberculosis verrucosa) of the right hand.

Figure XLVI.—Condition cured after treatment.

## PATIENT XXI.

Figure XLVII.—Keloid scar on the flexure of the elbow joint in male, aged twenty years. Onset after a burn with resin six months previously.

Figure XLVIII.—Result six months after treatment.

## PATIENT XXII.

Figure XLIX.—Rodent ulcer in the left supra-orbital region of six years' duration on patient aged fifty-eight years (not well shown on account of the reduction in size of picture).

Figure L.—Second photograph three months after treatment (result not well shown).

## PATIENT XXIII.

Figure LI.—Cavernous angioma involving the left cheek since birth in patient aged fifty years.

Figure LII.—Result twelve months after treatment.

## A PEEP INTO THE PAST: EARLY AUSTRALIAN SURGERY.

By NORMAN J. DUNLOP, B.A., B.Sc., M.B., Ch.M. (Sydney),  
Consulting Surgeon, Newcastle Hospital,  
New South Wales.

## PART I.

## Introductory.

IN my researches for material for a biography of William Bland, patriot, pioneer and surgeon, which I hope to publish later, I came across an interesting paragraph in the issue of *The Lancet* for September 29, 1832, under the caption "Benevolent Asylum, Sydney, New South Wales. Ligature of the Arteria Innominate." The paragraph goes on to say that "on Monday, the 26th of March, 1832, the operation for tying the *arteria innominata* for an aneurysm situated near the origin of the right subclavian artery was performed by W. Bland, Esq., assisted by Dr. Fattorini, in the presence of Drs. Smith, Ross and Rutherford, R.N., and Jacob of the East India Company's service. The patient up to this period (9 o'clock in the evening of March 28), that is fifty-three hours since the operation, is doing well and has not suffered either from pain, any disturbance of the sensorium or from other unpleasant symptoms, but on the contrary is already almost entirely relieved from the previous numbness of the right arm and hand, which is now no longer perceptible except in a very slight degree at the tips of the fingers. The further report of this case will be forwarded at the next earliest opportunity." The "next earliest opportunity" occurred and *The Lancet* for October 20, 1832, published a full account

of the case, including the previous history of the patient, the stages of the operation, the details of the after treatment, the death of the patient on the eighteenth day, the dissection and *post mortem* findings, together with Bland's comments on the case generally, which will be considered in Part II. of this article. But besides discussing Bland's surgery and his inventions, it will not, I think, be altogether uninteresting to say in the briefest possible way (a mere catalogue of the events in his life's history, in fact) something about this remarkable man himself.

## The Family of Bland.

William Bland was a member of the well known family of that name, whose ramifications spread over many counties in England and Wales; representatives of the family are also to be found in Ireland, North America and elsewhere. In "The History of the Ancient Family of Bland" by Carlisle, we read that one "J. Bland, M.D., of Number 6, Charter House, whom misfortune might have compelled to become one of the 'Brothers' of that munificent establishment which will perpetuate the name of Sutton with love and veneration to the latest posterity." This is interesting from the fact that it is possible, if not probable, that Sir John Bland Sutton, the world-known surgeon of London is a member of this ancient family and a relative of the subject of this paper. William Bland, the son of Robert Bland, M.D., an eminent obstetric authority and writer, was born in London on November 5, 1789, being one of a family of four children, two boys and two girls. His elder brother, the Reverend Robert Bland, B.A., of Pembroke College, Cambridge, one of the greatest classical scholars of his day, was a friend of Lord Byron and an elegant writer himself. Byron makes frequent complimentary mention of Robert Bland who was known by the name of "Don Hyperbolic," in his "English Bards and Scotch Reviewers."

## William Bland's Education.

Little is known of Bland's early years except that he was educated at Merchant Taylors' School where he received the usual secondary education of the period. After leaving school he became apprenticed to his own father; later he "walked" the hospitals and attended the lectures and demonstrations of the best known London professors and teachers. In 1809, at an early age, he qualified at the Royal College of Surgeons in London for the Naval Medical Services and afterwards received an appointment in the Royal Navy.

## The Duel and Afterwards.

Little did Bland know what the future held in store for him when he first placed his foot on the deck of one of His Majesty's ships. In 1813 we find him, as surgeon, on board His Majesty's ship *Hesper* on the Indian Station. Late in February, 1813, the *Hesper* arrived from a cruise up the Persian Gulf at Bombay. During the voyage and at Bombay Mr. Case, the purser of the ship, who seems to have been of a cantankerous disposition, had quarrels with several members of the ship's company; first he quarrelled with Mr. Fulton, the



master of the ship; then with Lieutenant William Randall, the first lieutenant, and lastly with Mr. Bland, the surgeon. Both Randall and Bland, owing to "the grievous nature of their insults," had received messages from Case demanding "the satisfaction of a gentleman" and were compelled, "by the law of public opinion" then in force, to face the ordeal. After some argument it was arranged that Bland and Case should fight the first duel and then, should Case still desire satisfaction from Randall, the second duel should take place. The first and only duel took place early in the morning of April 7 with catastrophic results. At the first shot Mr. Case fell mortally wounded in the abdomen and survived only a few hours. The next day Mr. Fulton, friend of Mr. Case, Mr. Buchanan, surgeon of His Majesty's ship *Arrogant*, Mr. Bland and Lieutenant Randall, the friend of Mr. Bland, were all committed by the coroner on the charge of wilful murder and were sent to gaol. The case was tried before the Recorder of Bombay on April 14 and 17, with the result that Mr. Fulton and Mr. Buchanan were acquitted, while Bland and Randall were found guilty, but with a strong recommendation to mercy. The Court then pronounced the sentence of transportation to New South Wales; Mr. Bland was to serve seven and Lieutenant Randall eight years. Bland was at this time only twenty-five years old. The prisoners were detained in India till the following year when they left Calcutta in the ship *Frederick*, commanded by Captain Duncan, for New South Wales *via* Hobart Town. After some delay in Hobart Town the *Frederick* reached Sydney on June 18, 1814. Randall lived only eight years after reaching Australia and died at Bland's house in the year 1822. The notice of his death appeared in the *Sydney Gazette* for August 25, 1822, and is as follows: "On Monday night last at the house of William Bland, Esq., Pitt Street, William Randall, Esq., formerly lieutenant in the Royal Navy, after a lingering and painful indisposition."

Soon after his arrival in Sydney, Bland was appointed as a professional prisoner in charge of the lunatic asylum at Castle Hill, but he only retained this appointment twelve months when he returned to Sydney where he was almost immediately emancipated and later in the same year (1815), pardoned. He was then offered a position as Assistant Colonial Surgeon, but preferring to be independent of the Government he started private practice in Sydney, enjoying the unique distinction of being the first private practitioner in Sydney and one of the first in Australia. Then began his long career of usefulness, extending over half a century, in the cause of philanthropy and Australian development which has seldom been equalled and never excelled. Australia over one hundred years ago was but a very small community lacking development and with many wrongs to be righted; Imperial burdens had to be lifted; the idiosyncracies and tyranny of the autocratic governors had to be resisted; autonomy and Australian emancipation had to be fought for; the condition of the free-sick-poor was deplorable and institutions for their accommodation had to be built; the means of providing the native born youth with a good educa-

tion had to be obtained; trial by jury, the freedom of the press and those other free institutions which we now enjoy, had with much pain and travail to be torn from hands unwilling to give.

#### Political.

Bland from the first flung himself whole-heartedly into all those activities having for their object the betterment of the colony and with his pen, his money and his great elocutionary powers did what he could to nurture the feeble plant of Australian settlement. Bland had high literary gifts and the facile pen of a ready writer; but that pen of his was a two-edged weapon which on one occasion (it was in the year 1818) during the struggle for political freedom, brought him into conflict with the Governor; and the Governor was for the time being the victor. Bland had written letters and verse criticising in a rather daring manner the conduct and administration of General Macquarie. The verse, which was signed "Lavater," was a bitterly sarcastic composition and a few lines from it referring to Macquarie's weakness of inscribing his name on all the buildings he erected, are worth quoting:

Thy puerile, weak ambition there I see  
That prompted thee to mark thy name on stone,  
And bids thee sigh and languish to be known.  
Like the rude younker who, with charcoal, scrawls  
And marks his name upon his schoolhouse walls!

For this Bland was arrested in the street, charged with libel and sent to Parramatta Gaol for twelve months. Bland also wrote to Earl Bathurst, the then Secretary of State for the Colonies, describing "the deplorable state into which the colony had fallen" and from his point of view the maladministration of the colony by the Governor. These letters reached Earl Bathurst in due course and were largely if not solely responsible for the visit of J. T. Bigge, Esquire, who came to Australia as a Commissioner to inquire into the truth of the charges made against Macquarie. Bigge confirmed, it is said, the entire contents of the letters sent to Earl Bathurst and his recommendations resulted in the recall of Macquarie, the end of the autocratic rule by the governors and the establishment of the first Legislative Council. In 1835 Bland with Wentworth, Jamison and others formed the Australian Patriotic Association. "The formation of this association was the outcome of a letter received by Sir John Jamison from Sir Henry Lytton Buller, recommending the colonists to form a political association without delay and to appoint a parliamentary advocate for the advocacy of their rights and never to relax their exertions until those constitutional rights which every British colony should enjoy, had been obtained." Of this association Sir John Jamison was President, Wentworth Vice-President and Bland, Secretary and a member of the Committee of Correspondence. Wentworth was practically the leader of this corporation and it is to him that we owe a debt of gratitude for sowing, with Bland's cooperation, those germs of constitutional government which have since grown into that mighty organism which we possess today. By their efforts the members of the Patriotic Association succeeded so far that in the year 1843, the first election of the



representatives of the people to the Legislative Council took place. At this election Wentworth and Bland topped the poll for Sydney. In his electioneering speeches Wentworth strongly advocated the claims of Bland for a seat in the Council. "If this contest were between me and the doctor only," said he on one occasion, "I should retire in his favour and even now I would say, vote for Bland in preference to me."

#### Bland's Plain.

In 1824 Hume and Hovell set out on their memorable journey of exploration from Lake George to Port Phillip and it was during their wanderings that Bland had his name put on the map of Australia. Hovell in his journal under the date Tuesday, December 14, says: "Having passed through the first plain, myself and Mr. Hume ascended a high but single hill in front, from which we saw a very gratifying sight. This was a very extensive plain, extending from west to south-east for several miles with patches of forest which appear to separate one plain from another. But the whole appeared in front, say south, to be level, but in parts in the plains some hills rose, with only here and there a few trees upon them, and all of the soil of the best quality. Mr. Hume named this plain Bland's Plain, in compliment to my friend Dr. Bland, of Sydney."

#### Education.

The cause of education in New South Wales had no more vigorous supporter or generous patron than Dr. Bland. Up till the end of the first quarter of the nineteenth century the young men of Australia lacked the advantages of a good education. For years there had been an urgent need for a good secondary school where the sons of the better class people could be educated, so in 1825 Bland with a number of other gentlemen formed themselves into a body of trustees "for the erection and endowment of a grammar school in the town of Sydney." The school was started in a rented house in Phillip Street with the Reverend Dr. Halloran, who had had educational experience in three continents, as head master, and a grant of land "near the race course," upon which it was proposed to erect the school buildings, was obtained from Sir Thomas Brisbane. The school which owing to various causes was not a success, remained open only about twelve months. In 1828 Bland made an attempt to resuscitate the institution and brought forward a scheme to raise £10,000 in two hundred shares of £50 each for the purpose of erecting the school buildings and to provide for their maintenance *et cetera*. Bland's suggestion was acted upon and on January 26, 1830, the foundation stone of the Sydney College (the name of the school was changed and its scope enlarged) was laid by Sir Francis Forbes, the Chief Justice of the Colony. The buildings which were then erected, are now occupied by the Sydney Grammar School. In 1853 an act was passed in the Legislative Council enabling the Sydney University to buy from the proprietors the Sydney College buildings and grounds; and Dr. Bland, the college president, was empowered to treat with the University authorities. Bland held the position of honorary secretary of the Sydney College almost

from its inception till the time the institution was handed over to the University. Another institution for the education and uplift of the people, the Sydney Mechanics' School of Arts, was established on March 22, 1833. This institution owes its origin to the untiring efforts of the Reverend Mr. Carmichael, A.M., and Mr. Robert Band, a brilliant young surgeon whose career of usefulness was early cut short by tuberculosis. Bland was one of the earliest life members of the School of Arts and his help to this institution by contributions of books, gifts of money and personal service was immense. His good deeds were not forgotten, for Sir William Windeyer in his jubilee address at the School of Arts in 1883 refers in a very kindly manner to Bland's services. "To Dr. Lang, Mr. William Bland and Sir Henry Parkes, veteran friends of popular education," said Sir William, "this institution is indebted for able support and substantial tokens of their interest in its welfare." In the year 1849 when the bill for the founding of the Sydney University was being discussed in Parliament, Robert Lowe, afterwards Lord Sherbrooke, made a wicked and bitter attack on Bland. The bill was considered in Committee and nearly all the clauses were adopted, when a difficulty arose over the clause containing the names of the members of the first senate. The list included the name of William Bland and Lowe very strongly expressed himself against the proposal to have this man on the senate. In his speech in the Legislative Council on October 10, 1849, Lowe said: "I have two objections against the bill which I will state to the House. The first is that persons who have been transported to this country, may be eligible to become members of the senate; the second is that the management and government of the university is to be given over to the graduates themselves, as soon as they amounted to fifty in number." He also gave notice of his intention to resign his own seat immediately if he and Bland should both be elected as senators. The report of this speech appeared in the *Sydney Morning Herald* for October 11, 1849, and was read by Bland before breakfast, probably after he had been out all night struggling with a persistent occipito-posterior presentation, as he was not in "that calm and heavenly frame" about which Cowper so sweetly sings. He immediately dashed off and sent to Lowe a very torrid letter, which may still be seen in the archives of the Mitchell Library. Read the letter!

October 11, 1849.

SIR: I have this moment read the report of your speech of yesterday evening in the *Sydney Morning Herald* of today and I feel no doubt that you have used your position in the Council to vent your private malignity against me. I am, however, recommended not to call upon you for the satisfaction of a gentleman, because you have on more occasions than one (where the claim for reparation from the nature of the insult was even stronger than in this case) in a manner the most cowardly evaded it. I shall, therefore, content myself on this occasion with merely expressing my opinion, that you are a coward and a scoundrel; but which opinion I shall be happy to retract if it is in your nature to give me an opportunity.

I am, sir,

Your most obedient servant,

W. BLAND.

Neither Bland nor Lowe became a senator. Lowe was an exceedingly able man, an albino, with such



defective vision that, it was said, he could not write a legible letter in ink as his nose was so close to the table when he was writing that it used to smudge whatever he had committed to the paper; and so crossed-grained was he, that it was exceedingly difficult to get on with him. An epitaph was written for him which, it is said, so much amused him that he turned it into Latin verse. The epitaph is so descriptive of his character that it may not be out of place to insert it here:

Heaven rest his soul!—but where 'tis fled  
Can't be imagined, much less said;  
If he the realms above us share,  
No more will love or peace be there;  
But if he's gone to lower level,  
Let us commiserate the devil!

#### The Benevolent Asylum.

An institution very near to Bland's heart and one to which he freely gave his time, his money and his skill, was that grand old parent of the Royal Hospital for Women, the Renwick Hospital for Infants and other activities—The Benevolent Asylum of New South Wales. The buildings of the asylum stood for many years, until the encroachments of modern Sydney necessitated a change of locality, on part of the land now occupied by the Central Railway Station. The Benevolent Society of which the asylum was a part, was instituted on June 5, 1818, and had for its object the relief of the poor, the distressed, the aged and the infirm. Bland was the gratuitous surgeon to the society from its inception, doing work which gained him the admiration of all sections of the community, from the Governor at one end down to the most abject dead-beat at the other. In 1825 General Darling visited the asylum and expressed his desire to see it placed on a footing which would render it more efficient, by providing increased accommodation for the inmates with hospital rooms and workshops. Following this visit the committee wrote to Bland asking him to submit a statement of the alterations and additions necessary to convert the asylum into a hospital. Bland's suggestions were: (i.) "That these alterations and additions contain wards or rooms for thirty or forty patients suffering from acute or bad protracted conditions, such only as require medical attention; (ii.) that the closets be ventilated and lighted by a window to open in the external walls of the building to supersede as far as possible the use of night chairs on each floor for the hospital. These to be recommended also (from a consideration of the large number of bed-ridden patients that is received into the institution) for the other departments of the building generally; (iii.) baths leaded and so constructed as to be available for the triple purpose of warm and cold bathing and the shower bath. Any additional expense for the rendering of the baths fully efficient would not be ill-laid out, but would be amply repaid in the greater advantages which they in this state would present. These baths to be distinct (the one for the male, the other for the female patients) one on each floor; (iv.) a dead-room for the reception of those who die in the institution; this to be furnished with a strong, plain table, about seven feet long and three broad; also with a strong, plain wooden slab attached (that

it might occupy the less space) to the wall of the room, so that, when not used, it may be let down: the table and slab for the purposes of dissection. This room should, if possible, be well lighted from the top by means of a sky-light. Thus constructed and furnished the room could be convertible, when required, into an operating room, for the purposes of which the table would be equally appropriate and useful." A morgue would hardly be the place chosen by the twentieth century surgeon as an appropriate room for operations! The alterations and additions were completed and the hospital was ready for occupation by 1832. The asylum was now, at once, a refuge for the distressed, a hospital for the diseased, the first general hospital in Australia for the free sick-poor, an asylum for the aged poor and a home for the wretched wanderer. The work of the hospital and asylum about this time so increased that it was found necessary to appoint a resident surgeon and Dr. Cuthill received the appointment of resident surgeon and dispenser. In 1832 Bland began that course of surgery which called forth the admiration of the British, European and American surgeons, as well as those of Australia. Here in the dead-room of the Benevolent Asylum, he performed operations which up to that period had never been attempted in the colony and his success was equal to that attained in any other part of the world. In 1826 the lying-in branch of the Benevolent Society underwent a reorganization under the patronage of Mrs. Darling and was conducted as a separate establishment, distinct from the Society. This, surely, is the pioneer attempt at special hospitals in Australia. On March 24, 1828, Governor Darling highly commended Bland for his work at the Benevolent Asylum to the Colonial Office in London. In a dispatch on the date referred to he wrote: "I cannot close this communication without mentioning to you in terms of merited approbation the names of the Reverend Mr. Hill, the secretary, and of Mr. Bland, the medical attendant, whose exertions are unceasing and on whom, in fact, the labour of conducting the establishment rests. Dr. Bland receives no fees for his work." In 1830, on account of his great services as well as his pecuniary assistance to the asylum, William Bland was unanimously elected a life member of the Benevolent Society. About this period owing to excessive zeal on behalf of the sick and afflicted, Bland was laid aside for over two months, but on the return of health he resumed once more the work he loved so well. He continued to give honorary service to the Benevolent Asylum till late in the 'sixties, when advancing years compelled him to curtail his efforts and conserve his strength. Dr. Bland had as colleagues at the Benevolent Asylum Drs. Nicholson (later Sir Charles), Wallace, Mr. A. a'Beckett, Dr. Fattorini, Mr. Robert Band and others.

#### The Sydney Dispensary.

The Sydney Dispensary was founded with Bland as the chief actor in August, 1826. The object of the institution was to provide treatment for the free sick-poor in their own homes and to have an out-patients' department for the ambulatory cases. At



the opening ceremony the Dispensary received the congratulations, with the promise of cooperation when its aid other than medicine was required, of the Benevolent Society. A subscription of one pound annually, constituted a member of the dispensary with the right of having at all times one patient on the books; two pounds provided the privilege of two patients and larger annual subscriptions in the same proportion. The town was divided into four parishes and these were subdivided into districts for the convenience of the visitors. The visitors whose functions were to find out cases of sickness, to inquire into the social condition of the applicants for relief and to sign the recommendation forms which were to be delivered to the doctors, were members of the committee. To each district a visitor and medical officer were appointed. The Dispensary began its operations in Macquarie Street, but later it occupied one of Terry's buildings in Pitt Street. It is interesting to know that the Australian Subscription Library, now the Free Public Library at the corner of Bent and Macquarie Streets, which began operations on December 1, 1827, was housed in the same building and the dispenser of the one institution acted as temporary librarian to the other.<sup>(1)</sup> Bland at this time lived in Pitt Street in a house erected on the land now occupied by the Commonwealth Bank. The first few years of the life of the Dispensary were lean years and owing to the lack of funds the whole enterprise was threatened with extinction, but this calamity was averted and the work of the Dispensary so increased that it was found imperative to appoint a resident surgeon to assist the gratuitous medical officers. Out of all the applicants for the position, Frederick Mackellar, M.D., was chosen on account of his great experience in dispensary work in Great Britain. Shortly after Dr. Mackellar's appointment, Mr. Russell, surgeon of His Majesty's ship *Pelorus*, imported a supply of excellent vaccine lymph and this was made use of by the Dispensary for vaccinating the children. At first the parents did not take up the matter of vaccination with much enthusiasm, but it soon became the vogue and four hundred and twenty children were successfully vaccinated between July 2 and October 1, 1840; also a supply of lymph was distributed between W. V. Thomson, Esquire, Inspector-General of Hospitals, for the use of Her Majesty's Government, and sixty or seventy medical and private gentlemen in the country districts, including Port Phillip, Bay of Islands, Port Nicholson and New Zealand. On account of the growing wants of the sick-poor additional accommodation and increased facilities for treating the cases became an urgent matter and an application was made to the Governor for an allotment of ground on which to erect a building suitable for a dispensary. A piece of land was suggested by the Deputy Surveyor-General and Commanding Engineer by his Excellency's directions, near the Benevolent Asylum, but this site the committee considered unsuitable for a dispensary; they then transmitted a memorial, signed by the Honourable

Alex. MacLeay, the President of the Dispensary, to the Right Honourable the Secretary of State for the Colonies, through his Excellency the Governor, praying that the south wing of the Macquarie Street Hospital be granted for the use of the Dispensary and for a free hospital under public trust and management and supported by private contributions. The memorial reached the Secretary of State for the Colonies and that gentleman was favourable to the prayer of the committee, but the heads of other departments opposed the scheme and it was only after copious correspondence and considerable delay that the occupation of the south wing of the infirmary was granted "on the distinct understanding that the option of resuming the buildings at any time that it may be required for public service is reserved to Her Majesty's Government."<sup>(2)</sup> Besides the fact that the aid afforded by the Dispensary had been found inadequate to the growing wants and necessities of the poor of Sydney, there were other reasons why the committee of the Dispensary desired the south wing of the Infirmary, and these may be briefly stated. The Dispensary Committee considered that they were paying too high a rent for the premises they were then occupying; there was a Government announcement that after a certain date no free person would be admitted to the General Hospital; and lastly but by no means leastly the committee who were men of vision, had the idea "of forming the commencement and nucleus of a medical school where the rising youth of the colony could acquire a knowledge both of the structure and diseases of the human frame." Many alterations and repairs were necessary before the south wing could be made fit for the reception of patients, but everything was in order by the end of June, 1845, and on July 3 the building was opened for the admission of those requiring hospital treatment. In the month of July, 1845, it was resolved: "That the institution known as the Sydney Dispensary be reconstituted under the name of the Sydney Infirmary and Dispensary." The Sydney Infirmary and Dispensary was the immediate ancestor of the Sydney Hospital of today. Bland was a life member of the Dispensary and was one of its medical officers from the time of its birth till it became the Sydney Infirmary and Dispensary. The idea of forming a medical school was never lost sight of and not long after the occupation of the south wing, we find young men being enrolled as students of the hospital. The late Drs. F. Milford and J. C. Cox were early students of the infirmary; the former was enrolled in 1849, the latter in 1850.

#### The Australian Medical Association.

During the first half of the nineteenth century there was not much cohesion or cooperation among the members of the medical profession. Each practitioner played a more or less lone hand and had to solve problems and overcome difficulties single-handed. At the Infirmary and other medical institutions the various staffs would meet occasionally in an informal way to discuss matters of parochial interest, but a society for mutual help and protection and the advancement of medical science generally did not exist. In the year 1858, Dr.

<sup>1</sup> The Australian Subscription Library came into existence on February 3, 1826, with Lieutenant de la Condamine, A.D.C., as secretary.

<sup>2</sup> The south wing of the Infirmary is now the Sydney Mint.



Robertson, a philanthropist full of the milk of human kindness and much devoted to the welfare of the profession and the community, conceived the idea of starting or founding a society which would have for its objects "the promotion of mutual respect and good fellowship amongst the members of the profession; the consideration of such matters as would lead to the general advancement of it; and for the collection of a benevolent fund for the use of the poor and sick fellows, their widows and orphans." With these objects in view Dr. Robertson gave several evening entertainments at his own house, at which gatherings the subject of forming a medical association was discussed. The matter was taken up with much enthusiasm and The Australian Medical Association was soon *un fait accompli*. The first regular meeting took place at the Exchange on the evening of February 28, 1859, with an enrolment of eighty-seven fellows, amongst whom were the Honourable William Bland, M.L.C., Mr. A. a'Beckett and others. The Australian Medical Association was a living thing for many years and did much good work for the advancement of the profession. Bland, as usual, was a very energetic member of this society, writing scientific papers and doing a phenomenal amount of work in the interests of the association. The officers of The Australian Medical Association for 1859 were: President, The Honourable William Bland, M.L.C.; Vice-President, the Honourable Dr. MacFarlane; Secretary, Dr. Robertson; and Treasurer, Dr. Bartholomew O'Brien, a member of the first Senate of the University of Sydney.

#### The Medical Profession in Politics.

To the honour of the medical profession be it said that it has always taken a keen and practical interest in the welfare of the community and the development of Australia. Bland from the date of his arrival with all the vigour of which he was capable, worked incessantly for local autonomy and all those free institutions, which are our heritage. It has been said of him that "his efforts in the cause of Australian emancipation entitle him to rank with Wentworth amongst the greatest benefactors of the community." In the first elective Parliament of 1843, the profession was represented by William Bland and Charles Nicholson, old colleagues on the staff of the Benevolent Asylum and Sydney Dispensary. Charles Nicholson achieved greatness; he had a baronetcy conferred on him, was three times elected Speaker of the Legislative Council, had honorary degrees conferred on him by several English universities and was a warm friend and generous benefactor of the Sydney University, of which he was Provost for a time. From the first election till the latest, medicine has been worthily represented in the Legislature of this country. Bland was defeated in the election of 1848, but in the year 1858, after we had gained full representative and responsible government, he became a member of the nominee or upper house. The Honourable William Bland, M.L.C., took his seat in the Legislative Council on March 24, 1858, and remained a member of the Council till March 21, 1861, when his connexion with the Parliament of New South Wales ceased.

## Reviews.

### MALARIA.

THE Division of Tropical Hygiene of the Commonwealth Department of Health has recently issued a number of reports. Among them there is one (Service Publication Number 3) on Malaria.<sup>1</sup> The author, Dr. R. W. Cilento, is to be congratulated on the thoroughness with which he has compiled this work and on the judgement and knowledge he has displayed in handling a very large subject. The title of the work is, perhaps a little misleading, for the greater part of the matter is an admirable summary of the knowledge collected by authorities in all parts of the world and but little has any actual reference to the disease as it exists in Australia and its dependencies. The work may be accepted as a reliable and authoritative statement of the teachings on the several aspects of malaria at the present time.

The work is divided into four parts. In the first we have a general treatment of malaria. There are chapters on the definition of the disease, on its history, on its distribution, on its endemology, epidemiology and ætiology and lastly on the causative parasite. This part is pleasantly written and contains much that is of interest.

The second part covers the disease, with its cause, pathology, complications and treatment. Practitioners who are called upon to take charge of patients with malaria, will find much that is useful and surprisingly little that is confusing. Malaria is a disease essentially of contradictions and anomalies and the achievement of the author in drawing a clear and helpful picture of the many forms and variations of ague without leaving the impression that the pathology still requires to be revised and amplified, merits recognition. His treatment of blackwater fever is guarded and perhaps a little indefinite; it would have been advantageous had he devoted more space to this important complication of malaria and to have risked a little by adopting a more decided attitude in regard to its ætiology. For teaching purposes it is necessary to make positive statements and even if these statements should prove at a later date to be incorrect, less harm is done in making them than in leaving it to the inexperienced reader to do so when the selection lies between two or more conflicting doctrines. We have not hesitated in describing blackwater fever as a complication of malaria. In this part there is another somewhat serious defect. The divisions and sub-divisions are not distinguished by captions in properly graded type. Owing to the somewhat illogical employment of different types for the cross headings, it is a little difficult to recognize at first when a new subject is being attacked and when merely a fresh sub-division is under discussion.

Part three is not as good as the preceding parts. The author is less happy in his expressions and the presentation is neither as clear nor as facile as that in the earlier chapters. Nevertheless he has included a great deal of very valuable information in the thirty-six pages comprising this part. The subjects are the measures for attacking mosquitoes, such as drainage, oiling, the use of fish, clearing and filling, trapping and flooding, the measures of prophylaxis of malaria and the like.

The fourth part takes the form of an appendix. In it there is a very excellent zoological account of mosquitoes in general and mosquitoes that infest Australia and her dependencies in particular. Dr. Cilento has wisely refrained from entering into too great details in regard to the morphological qualities and peculiarities of the several species and varieties, but has given all the essential landmarks for a field worker.

The usefulness of this publication and the skill displayed by its author in its compilation remain unchallenged by the few foregoing hypercritical remarks. Indeed we may go farther and state that from the point of view of the tropical hygienist the work deserves nothing but praise.

<sup>1</sup>"Malaria, with Especial Reference to Australia and its Dependencies," by R. W. Cilento, M.D., B.S., D.T.M. & H., Service Publication (Tropical Division, Commonwealth Department of Health) No. 3; Albert J. Mullet, Government Printer, Melbourne. Not dated.



# The Medical Journal of Australia

SATURDAY, NOVEMBER 1, 1924.

## The Right of Reply.

THE delegates of the local associations of members of the New South Wales Branch of the British Medical Association at their annual meeting with the Council of the Branch recently discussed the somewhat knotty problem of the defence of the medical profession against attacks made by non-medical persons in newspapers. From time to time the layman delights to shoot a dart at the British Medical Association. Often the attitude adopted by the local Branch of the Association or some action taken by the local Council is misinterpreted in the news columns of the daily papers or information is given in a misleading fashion. Not infrequently the source of the information in the daily press is this journal. On one occasion a letter was sent to a certain daily paper from this journal, indicating the incorrect interpretation that had been given of some action reported in our columns. This letter was not published, despite the fact that the editor of the newspaper in question was interviewed and promised to insert it. Replies have been submitted to attacks in the newspaper on the medical profession or on individuals and these replies have either not been published or a shortened version has appeared with the most essential parts deleted. The delegates found that the public were permitted to form a false opinion of the views and actions of the New South Wales Branch of the British Medical Association, because no contradiction of these misstatements and attacks found their way into the political papers. While this state of affairs is perhaps worse in New South Wales, the British Medical Association in all parts of the Commonwealth labours under the same disadvantage of being attacked and not having a reasonable opportunity of defending itself. It is obvious that the most effective and most dignified procedure would be the publication of a letter composed and signed by the responsible officers of the Branch

Council. During the lodge dispute some years ago the Victorian Branch deputed the duty of drafting letters or paragraphs for publication in lay newspapers to a small sub-committee of the Council and these contributions were accepted and printed. In this way the public was informed of the attitude of the Branch and of the reasons for its actions. In England the British Medical Association takes the public into its confidence somewhat more freely than do the several Branches of the Association in Australia. It is possible that the disinclination on the part of the newspapers to open their columns to the medical profession here is in some measure due to the reticence on medico-political matters of the Councils. Whether this is so or not, it is unfortunate that the public is not given a chance to learn the point of view of the medical profession. The delegates of the New South Wales Branch recommended the Council to utilize the columns of THE MEDICAL JOURNAL OF AUSTRALIA for this purpose, although it was realized that a professional journal does not reach many non-medical readers. Another suggestion was that The Australasian Medical Publishing Company, Limited, should publish a popular monthly magazine in which matters of public concern could be brought to the notice of the general community. There are many hygienic and medical subjects that should be discussed in a popular paper of this kind, for it is universally recognized that preventive medicine cannot be wholly successful unless the people collaborate with the profession and each individual plays his large or small part in the great endeavour to eradicate disease. The public should be educated in several directions in order that disappointment in regard to useless remedies for fatal diseases may be avoided and an intelligent appreciation of the advances in medical science may be gained by the public. In such a publication it would be easy to inform the public as to the principles on which the medico-political actions of the profession are based and thus to remove many misconceptions. But it would be impossible to utilize a popular magazine for the defence of unjust attacks on individual medical practitioners or for a reply to stupid aspersions against the British Medical Association or the medical profession in connexion with a breach



of ethical behaviour. The most that could be done in this regard would be to explain the constitution of the British Medical Association and the limitations of its powers in dealing with ethical offences. It is probable that the Federal Committee and the Directors of The Australasian Medical Publishing Company, Limited, will consider this suggestion in the near future. If it be decided to establish a popular magazine, very little difficulty should be experienced in making the necessary arrangements and in providing an organization suitable for the purpose. In the meantime it is not improbable that some of the great daily newspapers may grant to the Branches of the British Medical Association the right of reply on the ground of fair play.

### Current Comment.

#### DUODENAL DRAINAGE AND THE BILIARY TRACT.

THE use by Einhorn of a tube for insertion into the duodenum opened up the way for the employment of additional methods of diagnosis and treatment of conditions of that part of the intestinal canal and of the biliary passages. Meltzer in 1917 recorded some observations on the result of the application of magnesium sulphate to the intestinal mucosa. He found that this substance caused a complete relaxation of the intestinal wall. He discovered, however, that this action did not take place if the salt was previously passed through the stomach. He suggested that the application of such a solution by means of a duodenal tube might cause relaxation of the sphincter of the common bile duct and allow an escape of bile. Lyon applied the suggestion made by Meltzer and adapted the procedure for use in the human subject. Since then much literature has grown up around the matter. Many workers, as is so often the case with a new method of diagnosis or treatment, hailed it as a panacea for all sorts of things and made claims for it which to the unbiassed person could not fail at first sight to appear extravagant. Others took an opposite view and expressed the opinion that the method was of little or no real value.

In regard to the actual method itself it may be stated that it consists in the introduction of the tube, lavage of the stomach, the allowance of a certain period of time for the tube to pass into the duodenum, the instillation into the duodenum of thirty cubic centimetres of a 25% to 50% solution of magnesium sulphate and the frequent aspiration of fluid for examination. It will be seen that use of this method requires skill, patience and sometimes repetition. The first bile to be drawn off is light brown in colour and as a rule is quite transparent. It is generally called "A" bile and is held to come from the common bile duct. The next bile to be

obtained is more viscid in consistence and is dark greenish-yellow in colour and is held by some to come from the gall bladder. It is spoken of as "B" bile. The last kind of bile to be obtained is more fluid in consistency and lighter in colour. It is supposed to come from the intrahepatic ducts and is described as "C" bile. It will be evident that if the sources of these different types of bile are as described, great possibilities in regard to diagnosis will exist. Moreover, if it could be looked upon as reasonably certain that contamination did not occur in the passage of the tube, these possibilities would be considerably enhanced.

An attempt has recently been made by Dr. Chester M. Jones "to establish a conservative estimate" of the value of duodenal drainage in the diagnosis of conditions of the biliary tract.<sup>1</sup> Dr. Jones states that much of the literature on the subject is not based on careful investigative work. He refers to the claims of Lyon, Smithies, Karshner and Oleson and White in regard to the efficacy of the method in the diagnosis and treatment of practically all pathological changes of the biliary tract. He also points out that Einhorn, Alvarez, Cutler and Newton held directly opposite opinions as to its value. He also says that their conclusions are based on rather indifferently controlled clinical studies. He adds that other workers in this field have confined their comment largely to the results of animal experimentation. He holds that the early extravagant claims made for the method have not been fulfilled and that to this early enthusiasm is due much of the criticism and pessimism with which the subject is viewed. The undoubted psychological effect of this method of treatment has been overlooked by many. Dr. Jones states that the unequivocal stand of Alvarez that the method is without value is as unjustifiable as the non-recognition of the psychological effect.

Dr. Jones discusses the experimental evidence bearing on the physiology of the gall bladder and the sphincter of Oddi. Doyon, Bainbridge and Dale, Freese and Okada showed experimentally that the gall bladder is capable of producing muscular contractions the frequency and intensity of which could be modified by various stimuli. Thus acid chyme in the duodenum increases the strength and frequency of the contractions, while morphine has the opposite effect. The mechanism controlling the activity of the gall bladder has been proved to depend on two sets of nerve fibres, motor and inhibitory. Meltzer postulated a coordinated nervous control of the sphincter of Oddi and of the musculature of the gall bladder. According to this hypothesis stimuli causing a relaxation of the sphincter induced simultaneously a contraction of the gall bladder and *vice versa*. Although this hypothesis was not proved experimentally, it formed the basis of the so-called Meltzer-Lyon method of non-surgical biliary drainage. Dr. Jones states that a review of the work by Bainbridge and Dale and by Okada indicates that although gall bladder contractions can be demonstrated, they are so slight as to require very delicate and highly magnified methods to show clearly their

<sup>1</sup> *Archives of Internal Medicine*, July 15, 1924.



existence. The large majority of gall bladders investigated by this method have thickened and fibrosed walls and it appears inconceivable to him that a chemical stimulus applied to the duodenal mucosa can produce contractions in gall bladders, diseased or otherwise, of sufficient magnitude to empty the organ. That magnesium sulphate does relax the duodenum in the majority of instances is definitely proved by the work of Frazer on animals. Dr. Jones accepts Frazer's evidence that the action of the drug is purely local in spite of the claims of Einhorn, Dunn and others. Recent work by Diamond appears to produce unanswerable proof of the inaccuracy of Lyon's original hypothesis. Diamond produced duodenal fistulae in dogs and repeated intra-duodenal injections of a solution of magnesium sulphate failed to cause expulsion into the duodenum of carmine which had previously been introduced into the gall bladder. Dr. Jones concludes that in the presence of such carefully controlled experiments and in the absence of experimental confirmation of Lyon's hypothesis it would seem illogical to accept any longer the view that there exists a crossed innervation between the sphincter of Oddi and the musculature of the gall bladder or that magnesium sulphate when introduced into the duodenum does more than cause a local relaxation of the duodenal wall and with it of the muscle fibres of the sphincter of Oddi.

If gall bladder contractions do not occur after introduction of magnesium sulphate into the duodenum, the so-called "B" bile loses its significance. In any case it has been shown clinically that "B" bile can be observed in the presence of an obstructed cystic duct and in absence of the gall bladder. Taking these facts into consideration Dr. Jones offers as a reasonable explanation of "B" bile the suggestion that the fraction of duodenal contents containing the highest concentration of bile pigments is merely that portion collected during the greatest flow of bile into the duodenum.

In spite of the adverse criticism made by Dr. Jones he holds that the method may be intelligently used and to great advantage both as a therapeutic and diagnostic measure. Attempts to treat chronic disease of the gall bladder by duodenal lavage seem to be illogical. The pathological changes in chronic cholecystitis lie in the walls of the gall bladder and not in the musoca or bile which it contains. In acute cholecystitis, when the organ is presumably under increased tension, prolonged complete relaxation of the sphincter of Oddi and the resulting free flow of bile may possibly aid in passive partial evacuation of the gall bladder and cause slight relief of symptoms. There is one type of disease of the biliary tract which can be successfully treated by this method. Infective or catarrhal jaundice may be relieved and its cure may be hastened by frequent duodenal lavage. Dr. Jones regards the procedure in such cases as logical, on account of the flow of bile caused by the local relaxation. The value of duodenal analysis as an aid to exact diagnosis is limited. A bacteriological study of the duodenal contents is of little value owing to contamination which cannot be excluded even by the most rigid

technique. An exception to this general statement must be made in regard to the detection of typhoid carriers. For diagnostic purposes the duodenal contents may be examined for bile pigments, cellular elements and crystalline elements. An abnormal pigment content of the bile may indicate the existence of one of several diseased conditions, but is not conclusive evidence of the presence of any single disease. Dr. Jones refers to observations which he published in this connexion in 1922. He believes that the high bile pigment concentration observed in chronic cholecystitis and cholelithiasis is not due to stasis of bile in the gall bladder, but is probably due to an associated disturbance of the liver. Bile-stained leucocytes and epithelial cells occur in the presence of an inflammatory condition of the biliary tract. It is not possible from the type of cell found to determine the exact level of the inflammatory process. These cells are found in catarrhal jaundice and also in acute cholecystitis. The information derived from their study, however, is largely confirmatory. In Dr. Jones's experience the finding of abnormal amounts of cholesterol, bilirubin or calcium bilirubinate has been of definite diagnostic value.

Dr. Jones reports the investigation of two hundred and seventy-four individual patients by duodenal lavage. He lays stress on two important points in his technique. In the first place the presence of the tip of the duodenal tube in the duodenum was checked by fluoroscopic examination. In the second place the fluid withdrawn by the tube was centrifuged at high speed. He claims that by these means more consistent and satisfactory results are obtained. Fifteen of the persons examined by him were in good health and were used as normal controls, two hundred and two persons suffered from twenty-seven different diseases. Fifty-seven persons suffered from cholelithiasis, in forty-two of these the diagnosis was confirmed by operation. In the normal persons no biliary sediment was present. Abnormal biliary sediment was found in seventy-six of the two hundred and two patients suffering from various diseases. In all but nine of these seventy-six the sediment could be accounted for by pathological changes of the biliary tract. In the remaining nine the sediment was unexplained. Abnormal amounts of crystals in the duodenal sediment were found in every patient but one of the fifty-seven with cholelithiasis. In this patient clumps of bilirubin and a large amount of bile stained columnar epithelium were found. In twenty-one of this group grossly abnormal amounts of bile stained cellular material were also found.

As a result of his investigation, Dr. Jones claims that the method is exceedingly useful as a diagnostic measure. He admits that the series of fifty-seven patients is a small one and says that the high proportion of positive findings may have been fortuitous. He lays stress on the fact that like any laboratory test it is subject to error and should not be employed in the place of ordinary and well-tried methods of examination. On the contrary the only valid excuse for its existence is that it may be used as an additional diagnostic procedure.



## Abstracts from Current Medical Literature.

### OPHTHALMOLOGY.

#### Cyclo-Dialysis in Simple Glaucoma.

R. CORDS (*American Journal of Ophthalmology*, May, 1924) is an advocate of cyclo-dialysis in simple glaucoma. He is supported by some German operators, Meller, Elschnig, and Salus. The reasons for his preference are the ease and safety of the operation, the few complications, the good effect on vision and tension, the ease with which the operation may be repeated and the fact that in refractory cases other operations may be made afterwards. The author uses a von Graefe's knife, making the incision five to seven millimetres from the limbus by cutting vertically on the fibres of the sclerotic. For separating the ciliary body from the sclerotic he prefers the styilet of Elschnig. He turns it a little so that the aqueduct may run out. The spatula is turned from right to left, so that the ciliary body is loosened as far as possible, at least at one-third of the angle of the anterior chamber being made free.

#### Sarcoma of the Chorioid Followed by Irido-Cyclitis of Both Eyes.

M. COHEN (*New York State Journal of Medicine*, June, 1924) discusses the possibility of sympathetic irido-cyclitis following a sarcoma of the other eye. Several instances of this have been reported. His patient, a man of thirty-five years, suffered from gonorrhoeal arthritis and gave a history of syphilis. While under treatment for the arthritis the vision of the left eye failed and ophthalmoscopic examination revealed a sarcoma of the chorioid. He refused enucleation. About a year later the left eye was seen to be inflamed and blood was seen in the anterior chamber. The condition was irido-cyclitis and the eye began to shrink. Three months later the right eye which up till then had been normal, became painful and partially blind. The condition here also was irido-cyclitis. The left eye was then enucleated and a necrotic melano-sarcoma was found, but no perforation of the sclera. Vision of the remaining eye was reduced to perception of hand movements. The author believes the evidence is in favour of sympathetic ophthalmitis following the necrotic sarcoma.

#### Cataract Extraction by Barraguer's Method.

R. AFFLECK GREEVES (*Transactions of the Ophthalmological Society of the United Kingdom*, 1923, page 223) reports the results of fifty-one cataract extractions in forty-nine patients by Barraguer's suction method. In thirty-one instances the lens was successfully extracted in its capsule; in

seven the capsule broke during operation, but the lens was removed by the instrument. In thirteen instances it was necessary to use the scoops. In seventeen instances vitreous was lost and in five there was prolapse of the vitreous after operation. Complete iridectomy makes the operation easier, but the edge of the cut iris may become included in the suction cup and prevent extraction. In thirty patients vision of  $\frac{1}{2}$  or  $\frac{3}{4}$  was obtained. A successful extraction leaves nothing to be desired, but the method has shown itself to be less certain in its results than extraction without the capsule.

R. FOSTER MOORE (*Transactions of the Ophthalmological Society of the United Kingdom*, 1923, page 232) reports a series of cataract extractions by Barraguer's method. The greatest disadvantage of the method is the frequency of vitreous loss and its consequences. In his series of thirty-eight patients there was a loss of vitreous in nine, that is 23.7%. In twenty-two instances the lens was removed entire in its capsule without vitreous loss, that is in 50%. "Novocaine" was used to paralyse the orbicularis muscle and proved satisfactory. The author regards the necessity of a complete iridectomy a disadvantage of the operation.

#### Graphic Method of Examining Ocular Motility.

W. R. HESS (*Revue Générale d'Ophthalmologie*, January, 1924) describes a graphic method of representing muscular paresis. A black chart is marked out in horizontal and perpendicular lines. Nine red dots represent the point of fixation and the cardinal positions of the eye and the muscle responsible for that position. The patient wears a red glass on one eye and a green glass on the other. He is armed with a rod carrying a green disc. Fixing each position in turn he is asked to cover the red dot with the green disc. Though he believes he is covering the red dot in reality he is not doing so, but marks out a quadrilateral figure which indicates quantitatively and qualitatively the paralysed muscle. The author claims that his method is quite different from the usual one with double images.

#### Iridotomy (Curran's Operation) for Glaucoma.

FURTHER experience has moderated H. Gifford's enthusiasm for iridotomy as an operation for glaucoma (*American Journal of Ophthalmology*, May, 1924). The operation certainly reduces the tension to some extent and many eyes seem to tolerate this degree of increased tension with little damage. The procedure is more useful as a temporary measure, preliminary to a more radical operation. The operation is not devoid of danger; troublesome hæmorrhage and injury to the lens have occurred in the author's experience. Simple puncture of the limbus appears to be nearly as

efficacious as the iridotomy itself, followed by massage and the use of eserine.

#### Enucleation of the Eyeball under Local Anæsthesia.

ANGUS MACGILLIVRAY (*Transactions of the Ophthalmological Society of the United Kingdom*, 1923, page 357) gives detailed instructions in regard to the method of producing anæsthesia of an eyeball by local injection so as to make enucleation painless. He begins with an 0.3 gramme dose of "Veronal" the night before operation and this is repeated after five hours. This is followed next morning forty-five minutes before the time of operation by a hypodermic injection of 0.25 to 0.5 cubic centimetre of "Trivalin-hyoscine" solution or 0.02 gramme "Omnopon" with 0.0004 gramme of hyoscine. The patient is kept quiet with his eyelids closed and with his ears plugged with cotton wool. Then 5% cocaine solution is freely instilled into the conjunctival sac with a few drops of adrenalin. Finally 2% "Novocaine" solution is injected from a five cubic centimetre syringe with a straight needle twenty-five centimetres long. The conjunctiva and sub-conjunctival tissues are raised from the sclerotic at a point as far behind the equator as possible in the interspace between the four recti muscles. Into the cone thus raised the needle is inserted from before backwards through the conjunctiva and Tenon's capsule down to the outer surface of the sclerotic and a few drops of the anæsthetic solution injected. This raises Tenon's capsule off the sclerotic. The point of the needle is pushed backwards, being always preceded by injection of some of the solution. The needle is kept close to the sclerotic all the way round until the optic nerve is reached and here one cubic centimetre of the solution is injected and the needle withdrawn. Three similar punctures and injections are made. Pressure from behind will force the fluid forward beneath the conjunctiva. The patient is kept quiet for fifteen minutes and the operation is then begun. The anæsthetic fluid is composed of "Novocaine" 0.6 gramme, sodium chloride 0.12 gramme, potassium sulphate 0.09 gramme, dissolved in thirty cubic centimetres of distilled water. After the solution has been sterilized, 0.46 cubic centimetre of adrenalin chloride solution is added.

#### The Use of Radium in Cataract.

A. B. MCKEE AND W. F. SWEET (*American Journal of Ophthalmology*, August, 1924) of the Stanford University, have investigated the result of radium application to cataractous lenses. A dosage of ten milligramme hours applied twice a week for eight treatments was employed. The radium, contained in a silver tube one millimetre in thickness, was held one centimetre from the cornea, the pupil being dilated. The results showed that the radium did no harm to the eye and that the cataract was unaffected.



## LARYNGOLOGY AND OTOTOLOGY.

## Cancer of the Larynx.

J. E. MACKENTY (*Journal of Laryngology and Otology*, February, 1924) gives a résumé of the statistics and the operative period and technique of laryngeal cancer in his own series of patients extending over a period of thirteen years. He questions whether extrinsic cancer will ever be amenable to surgery. He calls special attention to the high percentage of recurrence in all but those submitted to total laryngectomy, and to the recurrence of the disease in all the extrinsic and in many of the late, apparently intrinsic instances of the disease. The great majority of laryngeal cancers are squamous-celled and extremely malignant. He thinks that opening the larynx for better orientation should be avoided since the incision may bisect the growth and disseminate it. The author holds that only the most incipient cancers should be treated by any method other than the most radical. Before operation a metabolist determines the patient's chemical status and, if faulty, tries to rectify it. If the blood sugar cannot be brought to a safe limit, operation is refused. At operation a T incision is used and the larynx and trachea are skeletonized under local anaesthesia. The rest of the operation is performed under general anaesthesia, which is imperative only from the time the trachea is opened until the hypopharynx and oesophagus are closed. Great care is taken that not a drop of blood gets into the trachea. The wound is loosely closed and abundant drainage of the super-imposed tissues of the neck is essential. The drains are left in from five to seven days. For feeding an oesophageal tube may be worn for weeks if necessary.

## Affections of the Labyrinth.

WILLIAM MILLIGAN (*Journal of Laryngology and Otology*, May 1924) states that in affections of the labyrinth implication of the cochlear segment shows itself in nerve deafness and persistent tinnitus, implication of the vestibulo-canalicular system by vertigo, disturbances of equilibrium, nystagmus, nausea or actual sickness. A purulent infection may come by way of the internal auditory meatus or in rare cases by erosion of the *eminencia arcuata* from extra-dural or sub-dural abscesses. Infection may occur in fracture of the base, but the most frequent route is by way of the middle ear following erosions, as a rule, from chronic infective disease of the middle ear and only rarely from the acute infective form. Induced serous labyrinthitis is the form almost invariably resulting from acute purulent otitis media. Milligan thinks that erosion of the external semi-circular canal is the principal cause of circumscribed labyrinthitis and invasion of the *fenestra ovalis* in the diffuse type. The *fenestra rotunda* is a rare portal of invasion. The *promontoria* is frequently found destroyed in tuberculous otitis media. Defective drainage is the principal

cause of the invasion from the middle ear cleft. The types of labyrinthitis met with clinically are circumscribed, diffuse purulent and diffuse serous. Erosions seen should be left severely alone and a good post-aural drainage secured. If a fistula is discovered, Milligan states that over the portal might well be written: *Nemo me impune lacessit*. In the absence of definite symptoms it is an unpardonable offence to probe or curette it. Diffuse purulent labyrinthitis, however, calls for prompt and efficient surgical interference. Often in these cases the symptoms are predominantly static or predominantly acoustic. Milligan's practice is to leave the cochlear segment alone as much as possible. He ablates the static segment and merely removes the *pars promontoria* without interfering with the *columella*, a useful amount of hearing is frequently thus preserved. If, however, the function of hearing is destroyed the freer the drainage the better. Milligan prefers the "bridge" operation in which chisels and gouges are used. He has discarded the facial nerve protector and the burr. In cases of non-suppurative affections of the labyrinth as the pathology is still obscure, the founding of accurate treatment is difficult. The violent and sudden attacks of vertigo with sickness, tinnitus and loss of hearing, the attacks recurring at irregular intervals, may completely incapacitate the patient who may be otherwise apparently healthy. When treatment by non-surgical methods for considerable periods have been ineffective, Milligan recommends, as a *dernier ressort*, ablation of the labyrinth.

## Traumatic Abscess of the Nasal Septum in Children.

C. F. YERGER (*Illinois Medical Journal*, April, 1924) states that abscess of the *septum nasi* is of relatively infrequent occurrence considering the frequency of injury to the nose. The majority of the cases of traumatic hæmatoma and abscess occur in young children and are the result of slight trauma. Many on account of the insignificant trauma are not recognized and on this account or from neglect an unsightly nasal deformity follows. Hence every case of trauma of the nose in children should be carefully examined.

## Parotid Calculi.

W. H. IRVINE (*Canadian Medical Association Journal*, May, 1924) reports the occurrence of a tumour at the angle of the left jaw in a man of twenty-three, which had been present at least twelve years. The patient was in excellent general health. He had large tonsils and adenoids, but his teeth were healthy. Ten years previously he had had a quinsy which recurred a year later. The tumour was the size of a hen's egg, its walls merging into contiguous muscle. The mass was semi-cystic and deep pressure evidenced the presence of hard movable bodies, crepitation being noticeable. The tumour was removed through an incision over the angle of

the jaw. It was found to contain twelve calculi and there were smaller ones in the duct, the smallest being nearest to the mouth, the larger were in the tumour mass which was part of the parotid gland, though very intimately fused with the buccal muscular tissue. The calculi, graduated in size from that of a pinhead to that of a small pea, were hard and rough, inclined to be spherical, though somewhat faceted. Analysis showed them to be phosphatic masses coated with fibrin. Very few parotid calculi have been reported.

## The Directoscope.

C. G. RUSS WOOD (*Journal of Laryngology and Otology*, March 1924) describes an instrument designed by Hastinger, of Vienna, for the direct examination of the larynx. It consists of two spatulae hinged at the proximal end where they are attached to a handle and can be separated by a winged screw. One spatula acts as a tongue depressor, the other is a pharynx spatula at the end of which is a movable plate carried on a rod in a groove of the spatula. The instrument is used under cocaine anaesthesia. While it is in use, the patient's head is not fully extended, the spatulae are approximated as much as possible, the plate being well drawn up. The instrument is held in the right hand and the tongue spatula is passed in the middle line over the base of the tongue and epiglottis. When the arytenoids come into view, the rod carrying the plate is pressed to its full extent into the hypopharynx. Next the winged screw is turned separating the two spatulae, the plate presses against the vertebral bodies and the base of the tongue is forced forward exposing the larynx.

## Naso-Pharyngeal Fibromata.

HASSAN SHAHEEN BEY (*Journal of Laryngology and Otology*, June, 1924) states that in ten years in Cairo he had operated on twenty-eight patients with naso-pharyngeal fibromata. The commonest age at which the patients were first seen was from fifteen to twenty-five years; the majority were males. In none of his patients did the tumour arise from the maxillary antrum and in none was the growth multiple. The amount of destruction caused was remarkably small compared with sarcomata and other malignant tumours. The author advises operation. He gives calcium salts for two days previously. He never does preliminary laryngotomy or splits the soft palate. He snips the muco-periosteum with a large pair of scissors curved on the flat and wedges the tumour only with the blunt nose of the scissors. He removes some of the tumours by means of Luc's forceps through the external nares. When the growths are large, he performs Moure's lateral rhinotomy. He never has had occasion to ligature the carotid or to resort to packing. He has not hitherto had a recurrence. Of the twenty-eight patients operated upon, only one died and shock was responsible.



## British Medical Association News.

### SCIENTIFIC.

A MEETING OF THE NEW SOUTH WALES BRANCH OF THE BRITISH MEDICAL ASSOCIATION in conjunction with the Section of Hygiene and Preventive Medicine was held at the B.M.A. Building, 20 to 34, Elizabeth Street, Sydney, on August 28, 1924, Dr. ANDREW DAVIDSON, the President, in the chair.

#### The Control of Infective Disease.

Dr. W. G. ARMSTRONG read a paper entitled "The Duties and Responsibilities of the General Practitioner in Regard to Infectious Diseases" (see page 463).

Dr. R. DICK stated that as Dr. Armstrong had dealt with the duties and responsibilities of the general practitioner in regard to the control of infectious diseases, he would endeavour to deal with the problem of notifiable diseases from a somewhat different point of view. He pointed out that laws to be efficacious demanded the active cooperation of the people concerned. It was the desire of his department to obtain the cordial cooperation of the general practitioner in order to render the administration of the public health acts effective. Useful results could only be obtained by the officers of the department if there was real cooperation of this kind. When he had first taken on his duties as Medical Officer of Health in the Newcastle district he had not been favourably impressed with the state of affairs in this regard. The general practitioners had not shown him any keen interest in the work of prevention. Later, however, after he had succeeded in showing the general practitioners that he had no intention of interfering with them in their proper work and that he might be of use to them, a very cordial cooperation had been established between them.

In the first place he wished to discuss the problem of enteric fever. Formerly it had been quite common to treat a patient with typhoid fever in his own home. Later practically 90% of patients were treated in hospital. As a result of this improvement a great reduction in the incidence of the disease had been effected. The incidence had been reduced almost in direct proportion to the increase in institutional treatment. In regard to diphtheria it had been shown that isolation was essential and yet even when between 85% and 90% of patients were isolated in hospitals, there had been no reduction in the incidence of the disease. It was thus manifest that some other expedient would be required to control its incidence. The same observation had been made in all parts of the world. Before turning to the questions of the methods that were required, Dr. Dick commented on the small interest taken by the average general practitioner in the campaign against the spread of infective disease. He referred to the attitude of a certain practitioner who replied to a suggestion that something might be done to reduce the incidence of these diseases that it was useless; they always had a particular type of illness at certain periods of the year. "What was the good of any action being taken?" When the doctor was asked to search for carriers in order to trace the source of infection, he had said that he was not paid to do this work; the health inspector should do it. Dr. Dick was satisfied that it would pay the general practitioner to do this work, even under a contract system it would lessen the amount of non-lucrative work. A practitioner had refused to provide a sample of faeces for the detection of typhoid bacilli and had suggested that the patient should travel to Sydney, a distance of three hundred miles, if the department wished the material. Dr. Dick held that at times the general practitioner when he was very busy forgot to notify cases of infective diseases immediately; later he found that it was scarcely worth while notifying, as much time had elapsed. In this way some failed in their duty to notify the local authority. The department was loath to prosecute; possibly it might be advisable to prosecute once or twice. This would act as a warning.

In regard to the question of venereal diseases, Dr. Dick referred to the fact that it was commonly believed that

there was an immense amount of infection among the Australian community, especially since the war. Some general practitioners had not notified and had not realized their responsibility. In some instances they were undoubtedly shielding their patients. Some patients sought treatment from certain doctors who, it was alleged, were known to avoid notification. It was a difficult question. Nevertheless the returns of notifications showed that venereal disease in one form or another occurred in approximately 3% of the entire population. Dr. Dick asked whether that could be regarded as the true incidence of these diseases. In New Zealand a census had been taken on September 16, 1922, all practitioners being asked to make a return of the number of persons at that date under treatment for venereal disease. There was every reason to believe that the returns was reliable. The proportion of the population notified as infected was 2.4%. In Sweden and in Switzerland similar steps had been taken to ascertain the incidence of venereal diseases. The figure had been 4% for Switzerland and 3.4% for Sweden. New South Wales was apparently no worse off in regard to the notification of venereal disease than some other parts of the world. In the annual report of the Commissioner of the Health Service in New York it was stated that many practitioners did not notify venereal diseases. Similarly in the report of the department in Chicago reference was made to the laxity of medical practitioners in notifying venereal diseases.

It was a very remarkable fact in connexion with typhoid fever that despite the return of many soldiers who had been infected with one or other of the diseases of the enteric group, there had been no increase in the incidence since the end of the war. In the period 1910-1914 the incidence had been 12.4 per ten thousand of population; between 1919 and 1923, the incidence had been 4.1 per ten thousand. There had been much talk about the terribly high incidence of this disease and a clamour had been made for the control to be passed over to the Federal authority. Dr. Dick thought that the department had shown that it could do quite well without any such help. During the previous four months three typhoid bacillus carriers had been detected in connexion with outbreaks. One of the carriers was a nurse. In order to detect carriers they had to rely on the cordial cooperation of the general practitioner. The department kept accurate records of all known carriers and used this information for the control of outbreaks. Dr. Dick found that the hospital authorities were not particular enough in regard to infectivity of patients at the time of discharge. No investigations were as a rule made to ascertain whether the patient was still harbouring typhoid bacilli. He referred to the experience in the isolation camps in India where the patients were kept until proved to be non-infective. There was one difficulty. Some persons were intermittent carriers and repeated examinations were then necessary to discover the carrier state. More recently a method of testing persistent infectivity had been suggested. It consisted in the intracutaneous injection of typhoid vaccine. The method was being tested in Scotland and in England, but the results were not very encouraging. There had been no opportunity for trying the test in New South Wales.

The next disease with which Dr. Dick dealt was tuberculosis. This disease was notifiable in Sydney, in the Newcastle area and in the tourist district of the Blue Mountains. It was quite obvious that the notifications were not reliable indices of incidence. As a rule to each death from tuberculosis there would be ten infections. The notifications at times were as numerous as the deaths or they exceeded them in number to a slight extent. Where there was a good anti-tuberculous organization, the notifications were relatively more numerous. For example in Lancashire it had been estimated that only 8% of the infections were not notified, while in Bolton 40% were not notified. The British Minister of Health had issued a warning concerning the non-notification of tuberculous infections.

Dr. Dick gave a short account of the work that had been accomplished in the prevention of diphtheria. Dr. Ferguson, Principal Micro-Biologist of the Department, was conducting a campaign in this direction. The school



children in Parkes, Forbes and Narrabri had been subjected to the Schick test, after the consent of the parents had been obtained and some of those who proved to be susceptible, had been immunized with toxin-antitoxin mixture by private medical practitioners. Of twelve hundred children 22% responded to the Schick test. The susceptibility was more frequent in girls than in boys. Of the girls 36% had reacted, while of the boys only 17% had reacted. Dr. Ferguson and his assistant, Dr. Morgan, had carried out the testing. The campaign had been started locally. The local authority had applied to the department to carry it out and much assistance and collaboration had been received from the medical practitioners of the district. It had been determined to start the investigations in the metropolitan area and at Cessnock within a short time. The plan was to give each school child a slip to take home. The parents were asked to sign the slip, assenting to the application of the Schick test to the child. The medical officers stayed in the town at the first visit for forty-eight hours. The second and third visits were paid on the fifth and seventh days. The preventive inoculations were left to the general practitioner to carry out. No charge was made by the department for the performance of the Schick test. For immunization the toxin-antitoxin of the Commonwealth Serum Laboratories was used without charge to the medical practitioner or to the patient. In this campaign they had had the cordial cooperation of the medical profession in the localities mentioned.

In conclusion Dr. Dick stated that he had noticed that there had been much matter published in THE MEDICAL JOURNAL OF AUSTRALIA on the subject of national insurance and the prevention of infectious disease. He was doubtful whether the proposals put forward would result in much good. Under the English system preventive measures were not operative under the national health insurance scheme. The members of the medical profession in the Commonwealth apparently were not in favour of national insurance. He thought that more could be achieved by establishing a cordial cooperation between the department and the practising members of the profession than by any movement connected with national health insurance.

DR. H. G. WALLACE referred to the fact that only a short time before had he taken over the duties of the Medical Officer of Health at Newcastle and consequently he had not had much opportunity to ascertain the attitude of the general practitioner in regard to notification. He had been struck by the incongruity of the large number of deaths from tuberculosis as compared with the number of notifications. It was quite obvious that there was a good deal of tuberculosis in the Hunter River district. The figures between 1916 and 1923 were very instructive. During this period the number of notifications of living patients had been 459. Of these persons 107 were known to have died. On the other hand in the same period, according to the Registrar's returns, no less than 385 persons had died from pulmonary tuberculosis, so that it appeared that not more than one in three or one in four were notified. It was apparent that either the general practitioner did not notify the infections in patients under his care or that he did not diagnose the condition or that the patients did not go to a doctor. In busy lodge practice the doctor might not have the facilities to examine the patient thoroughly and in this way many infections escaped detection in the early stages. There were three essentials for the proper control of tuberculosis. The first was prompt notification, the second was the isolation of persons known to be infected or suspected of having an infection and the third was the prophylactic treatment of contacts. Under the favourable conditions of the tuberculosis dispensary over 80% of the patients were adequately isolated. Dr. Wallace referred to the clause on the notification form in which the notifying doctor was asked to set out whether or not he desired the health inspector to call. If he did not wish these visits, he accepted the responsibility of controlling the spread of infection. When the nurse inspector visited the patients, she performed many important tasks, not the least vital of which was to persuade the other members of the family to go to the dispensary to be examined for tuberculous infection. The department assumed that when the doctor asked that

the patient be not visited by the nurse, he would carry out all the necessary investigations. Dr. Wallace was convinced that a very large number of early infections were missed. He asked the members present to express an opinion concerning the advisability of removing this sentence from the notification form and thus making the visit from the nurse inspector obligatory. He added that the nurse was always tactful and her services were most valuable. He thought that it might eventually be necessary to compel all contacts to submit themselves to examination and supervision.

In the next place Dr. Wallace expressed the opinion that all forms of tuberculosis should be notifiable. The presence of a tuberculous affection of a bone, for example, led them to look for another member of the household with an "open" tuberculous lesion.

While the notification of diphtheria appeared to be prompt and thorough, the general practitioner often did not attempt to discover the source of infection and to fill in this information. It would be very helpful to the authority if practitioners would assist them in this matter. Immediate isolation of the patient preferably in a hospital was essential. In the course of twenty years the hospitalization rate, that was the proportion of patients treated in hospital, had risen from 6% to 85%. Simultaneously the case mortality had diminished from 23.7% to 4.7%. Unfortunately the isolation of persons suffering from diphtheria had not resulted in a reduction in the incidence. The incidence had actually increased nearly threefold in twenty-five years. The same applied to scarlatina. In 1904 2% of the patients had been treated in hospitals; in 1923 17% had been treated. In 1904 the case mortality had been 1.8% and in 1923 0.2%. In regard to enteric fever the effect of treatment in hospital was not as evident. While the hospitalization rate had risen from 49% to 89%, the case mortality had fallen from 11.2% to 9.3%. Bacteriological examination was essential in both diphtheria and enteric fever and yet in many country districts no attempt was made to carry out these bacteriological examinations before patients were discharged from hospitals or declared cured. It had been ascertained that from 3% to 4% of persons carried the bacillus of typhoid fever for weeks or months after recovery. A similar thing applied to diphtheria. In conclusion Dr. Wallace urged the importance of the general practitioner's responsibilities in connexion with contacts and carriers.

DR. J. S. PURDY, D.S.O., who was unavoidably absent from the meeting, had sent a note expressing his views on the subject under discussion.

The Metropolitan Medical Officer of Health asked for the cooperation of medical practitioners in facilitating the work of his staff. Over six thousand notifications of infectious diseases ultimately reached his office yearly after having been dealt with by the local authorities or in the case of pulmonary tuberculosis direct. The date of these notifications had to be scheduled by local authorities, the addresses verified, statutory notices served on householders and school teachers, isolation, inspection and disinfection of premises and possible action with regard to milk supply or other measures taken in the interest of the community.

On reaching the Medical Officer the notifications had to be card-indexed and filed, not only under the classification of diseases and local authorities, but also of the notifying medical practitioner, in order to check claims for payment on the required vouchers. In this latter regard it was found that the signatures of some practitioners were quite illegible. The signatures of others entailed the loss of considerable time and patience in deciphering. Especially was this the case with newly registered medical practitioners, the disguise of whose signatures had not become penetrable by familiarity. The practice coming into general use in America of adding the name in printed characters in addition to the signature was one which would save much inconvenience.

An examination of the notification forms sufficed to indicate that unfortunately the aspersions often cast on the business capacity of medical men, if the careless way in which the date was filled in was any criterion, was not unwarranted. Comment had often been made in the office



that the busiest practitioners were most exact in filling in the forms, thus adding further proof to the statement that the busiest men had the most leisure.

In filling in the notification form, the printing of the surname, a practice with which those practitioners with war service were familiar, was of considerable help.

The Christian name should never be omitted. The practice of using the terms "Mr.," "Mrs." and "Miss," son, daughter or lady often led to confusion. As far as possible the various items of information asked should be supplied, as such were of value in investigating and dealing with outbreaks of infectious disease. Notifications, to be of value, should be prompt. Such notification provided the data indicating any suspicious grouping of cases in connexion with school attendance, milk supply or other common foci or source of origin.

The general medical practitioner could assist the authorities not merely in being exact as to the routine of notification, but in giving advice to householders as to isolation, disinfection and other measures for curtailing the spread of infectious disease.

The ideal was for every medical practitioner to regard himself as a health officer to the family he attended. Any medical attendant who noticed any insanitary defect and cared to notify the fact in his remarks in the notification form or by telephone, could be assured that it would receive attention. A more close cooperation between the medical attendant and the health authorities would be of benefit to health officers and to the general public.

DR. E. H. M. STEPHENS asked if it would be practicable to enforce a regulation that children presenting certificates for absence from school on account of diphtheria or tonsillitis, should have swabbings taken to prove freedom from the Klebs-Loeffler bacillus before being allowed to resume attendance at school. He had found that many cases apparently of tonsillitis had proved on culture of swabbings to be infectious with Klebs-Loeffler bacillus and that the persistence of the Klebs-Loeffler bacillus for many weeks in children with diphtheria could only be detected by culture of swabbings and further infection by premature return to school thus avoided.

DR. C. H. E. LAWES wished to say a few words for the poor general practitioner who had had a rough time that evening. The general practitioner was not so bad as he had been painted. He was not only willing but anxious to help. It had been recognized that the general practitioner must be the outpost in any campaign against disease. The great majority, he felt sure, took that view. There were, however, some difficulties in regard to notification. It had been stated that the compulsory notification clauses of the *Venerable Diseases Act* were not being enforced and as a result that many practitioners had failed to notify. Again there was often some apprehension on the part of the patient. Although assured that the notification would be anonymous, the patient at times preferred to run no risks and therefore selected a practitioner who did not notify. In regard to the notification of other infectious diseases, Dr. Lawes pointed out that some of the clauses were not compulsory. These dealt with the information concerning the milk supply of the household, the school attendance of the patient and the like. It would in his opinion be better if the practitioner were actually required to supply this information. There would be no difficulty in ascertaining the facts. He thought that it would be distinctly advisable to delete the question concerning the visit of the nurse inspector in the tuberculosis notification form. The visit should be compulsory. At times it was not easy to report tuberculosis. The doctor might see the patient only once and there might be considerable doubt concerning the diagnosis. In the case of diphtheria there was no doubt. The tuberculous patient often came complaining of a cough and asking for some medicine to relieve it. At the first visit the patient might not be examined. Again many consumptives did not consult a doctor at all. Dr. Lawes claimed that the general practitioner was not unsympathetic. He was very important to the health department and was prepared to work together with the department to prevent disease.

DR. R. H. TODD thanked the members of the Section for arranging to have a joint meeting with the Branch. He regretted that the attendance was not better. In regard

to the question of the cooperation of medical practitioners with the health department an admirable suggestion had been made to him that evening. If the department approved and lent its aid, the local associations of members would be asked to arrange meetings to which the departmental medical officers would be invited. He felt sure that the country and suburban practitioners would grasp the opportunity of coming into close contact with the department in this manner and the basis for the desired cooperation would be provided. The Commonwealth Serum Laboratories had taken steps to this end and by attending meetings of the profession in the various localities of the State Dr. Penfold had reached a large section of the practising profession. If meetings of this kind could be arranged, no doubt authority would be given for the office of the Branch to help.

Dr. Dick had spoken of the unwillingness of the profession to support national health insurance and preventive medicine measures. The encouragement of preventive medicine had been under consideration for a long time by the Federal Committee and the Branches and the Federal Committee were making efforts to secure recognition of the general practitioner as part of the public health system. The necessity for a close relationship between the main body of the profession and the administrative medical officers had formed the basis of their deliberations. In regard to the *National Health Insurance Act* in England, it was not a public health measure and was understood not to have effected anything in reducing the incidence of infectious disease. He referred to the unwillingness of the medical profession to support any proposition based on the English panel system. The majority of practitioners were opposed to undertaking duties so massive and revolutionary, regarding them as unnecessary in Australia. The Commonwealth Royal Commission on National Insurance had invited the Federal Committee to suggest a practical scheme and the Federal Committee had drafted some proposals for the purpose. They were now in the hands of the Branches and it was possible that they might be the basis of a system of compulsory health insurance through Australia which would meet the requirements of the people and be approved of by the medical profession. He had reason to believe that the Commission intended to formulate a scheme of medical attendance on purely business insurance lines, the benefit being confined to people of limited incomes who could contribute to the cost of their insurance. The contributors would be the employees, their employers and the Government. He did not expect that the Commission would make any recommendations covering medical benefit to the unemployed and unemployable.

DR. ANDREW DAVIDSON thanked Dr. Armstrong and Drs. Dick and Wallace for their interesting contributions.

In the course of a short reply DR. ARMSTRONG said that practitioners engaged in the practice of public health did not get enough criticism in their work or sufficient opportunities of discussion with their brethren in general practice. He agreed with Dr. Lawes that the general practitioner was usually very anxious to render assistance to the department. The relations between the general practitioners and the Health Department throughout the long period during which he was associated with it, had been excellent. The department could not carry on without the countenance and assistance of the general practitioner. He went further and stated that public health legislation could not be adequately administered without the approval and sympathy of the public and of the medical profession.

THE INAUGURAL MEETING OF THE EYE, EAR, NOSE AND THROAT SECTION OF THE QUEENSLAND BRANCH OF THE BRITISH MEDICAL ASSOCIATION was held at the B.M.A. Building, Adelaide Street, Brisbane, on July 18, 1924.

The following office bearers were elected:

President: DR. J. LOCKHART GIBSON.

Vice-President: DR. W. N. ROBERTSON, C.B.E.

Member of Committee: DR. WALLIS HOARE.

Honorary Secretary: DR. ERNEST CULPIN.

It was resolved that meetings be held every three months.



On September 8, 1924, the members of the Section held an inaugural dinner at the Brisbane Club. Dr. D. GIFFORD CROLL, C.B.E., the President of the Queensland Branch of the British Medical Association, and Dr. A. C. F. HALFORD, the President of the Brisbane Club, were present as guests of honour.

Various toasts were honoured and Dr. Halford in responding to the toast of the visitors emphasized the interdependence of general practitioners and specialists.

#### NOMINATIONS AND ELECTIONS.

THE undermentioned have been nominated for election as members of the New South Wales Branch of the British Medical Association:

- BARBOUR, WILLIAM MCKIE, M.B., Ch.M., 1924 (Univ. Sydney), Hampden Road, Five Dock.  
CRAWFORD, CARLYLE GRAHAM, M.B., Ch.M., 1924 (Univ. Sydney), 363, New South Head Road, Double Bay.  
DOWNWARD, CHARLES ANTHONY, M.B., 1924 (Univ. Sydney), Loudon Avenue, Haberfield.  
JEREMY RICHMOND, M.B., Ch.M., 1923 (Univ. Sydney), Sydney Hospital.  
MACDONALD, RODERICK HECTOR, M.B., Ch.M., 1923, (Univ. Sydney), Sydney Hospital.  
MACVEAN, CHARLES BATTANDIER, M.B., Ch.M., 1924 (Univ. Sydney), Balfour Road, Bellevue Hill.  
MULVEY, ROY DADSON, M.B., Ch.M., 1923 (Univ. Sydney), Abbotsford Road, Homebush.  
PERDRIAU, OWEN, M.B., Ch.M., 1924 (Univ. Sydney), Berala, Nicholls Avenue, Haberfield.  
SWEETAPPLE, HAROLD ALGAR, M.B., Ch.M., 1921 (Univ. Sydney), Village Lower Road, Vacluse.  
TRAILL, JOHN ERIC, M.B., Ch.M., 1924 (Univ. Sydney), Clarence Street, Burwood.

### Post-Graduate Work.

#### NOVEMBER COURSE IN MELBOURNE.

THE MELBOURNE PERMANENT COMMITTEE FOR POST-GRADUATE WORK has issued the syllabus for the annual course which will be held during the fortnight from November 10 to 21, 1924. Members intending to join the course are requested to forward a notification to the Joint Honorary Secretaries, Post-Graduate Course, 12, Collins Street, Melbourne, before October 31. Later entries, however, will be received. The fee for the course is three guineas; a remittance should accompany the notification. A central information office will be placed in the Walter and Eliza Hall Institute for Research in Pathology and Medicine, Melbourne Hospital. This office will be open each morning during the course.

##### Monday, November 10, 1924.

- 9.30 a.m.—Registration at Post-Graduate Office, Melbourne Hospital.  
11.15 a.m.—MR. B. KILVINGTON: Demonstration of Surgical Cases at the Melbourne Hospital.  
DR. K. HILLER: Demonstration of Medical Cases at the Melbourne Hospital.  
2.15 p.m.—DR. S. FERGUSON: "Infantile Dietetics."  
3.30 p.m.—MR. W. KENT HUGHES: Demonstration of Orthopaedic Cases at the Children's Hospital.

##### Tuesday, November 11, 1924.

- 9.30 a.m.—MR. GORDON SHAW: Demonstration of Surgical Cases at the Saint Vincent's Hospital.  
DR. J. GRIEVE: Demonstration of Medical Cases at Saint Vincent's Hospital.  
11.15 a.m.—DR. L. S. LATHAM: Demonstration of Pulmonary Diseases at Saint Vincent's Hospital.  
MR. NEWMAN MORRIS: "Lesions of the Shoulder Joint," at Saint Vincent's Hospital.  
2.15 p.m.—DR. H. M. HEWLETT: "X-Ray Work in Children," at the Children's Hospital.

##### Wednesday, November 12, 1924.

- 9.30 a.m.—DR. R. MORRISON: "Some Common Gynaecological Problems," at the Women's Hospital.  
11.15 a.m.—DR. R. N. WAWN: "Toxæmias of Pregnancy," at the Women's Hospital.  
2.15 p.m.—DR. L. J. CLENDINNEN: Demonstration in X-Ray Work, Radiography, Technique and Interpretation, Dark Room Technique, at the Melbourne Hospital.  
8 p.m.—Social Evening.

##### Thursday, November 13, 1924.

- 9.30 a.m.—MR. MURRAY MORTON: "Surgery of General Practice," at Saint Vincent's Hospital.  
DR. J. MURPHY: Demonstration of Gynaecological Cases, at Saint Vincent's Hospital.  
11.15 a.m.—MR. JULIAN SMITH: Demonstration of Surgical Cases, at Saint Vincent's Hospital.  
DR. A. J. BRENNAN: "Laboratory Methods," at Saint Vincent's Hospital.  
2.15 p.m.—DR. H. F. PRAAGST: Demonstration on X-Ray Work, Radioscopy, Chest and Barium Work, at the Melbourne Hospital.

##### Friday, November 14, 1924.

- 9.30 a.m.—DR. S. V. SEWELL: "Causes and Management of Hemiplegia," at the Melbourne Hospital.  
MR. H. DEW: "Diagnosis and Treatment of Hydatids," at the Melbourne Hospital.  
11.15 a.m.—DR. D. THOMAS: "Constipation," at the Melbourne Hospital.  
MR. V. HURLEY: Demonstration of Surgical Cases from the Septic Wards, Melbourne Hospital.  
2.15 p.m.—DR. R. DOWNES: "Talipes," at the Children's Hospital.  
3.30 p.m.—DR. R. L. FORSYTH: Demonstration of Cases in the Wards of the Children's Hospital.  
8 p.m.—DR. ARTHUR MORRIS: "Treatment of Gonorrhœa," at the Venereal Diseases Department of the Melbourne Hospital.

##### Saturday, November 15, 1924.

- 9.30 a.m.—MR. W. A. HAILES: "Ankle Joint Surgery," at the Melbourne Hospital.  
DR. L. E. HURLEY: "Blood Diseases," at the Melbourne Hospital.  
11.15 a.m.—DR. C. KELLAWAY: "Applied Physiology of the Blood," at the Melbourne Hospital.

##### Monday, November 17, 1924.

- 9.30 a.m.—MR. A. TRINCA: "Infections of the Hand," at the Alfred Hospital.  
DR. W. S. NEWTON: "Asthma, Hay Fever and Allied Conditions," at the Alfred Hospital.  
11.15 a.m.—MR. R. C. BROWN: "Practical Points in Surgical Technique," at the Alfred Hospital.  
DR. J. R. ANDERSON: "Treatment of Conjunctivitis, Iritis and Other Conditions," at the Alfred Hospital.  
2.15 p.m.—DR. R. FOWLER: "Common Infections of the Female Urethra and Cervix," at the Alfred Hospital.

##### Tuesday, November 18, 1924.

- 9.30 a.m.—MR. J. GORDON: "When, Where and How to Amputate," at the Melbourne Hospital.  
DR. S. COWEN: "Chronic Non-Tuberculous Diseases of the Lungs," at the Melbourne Hospital.  
DR. F. B. LAWSON: Demonstration of Cardio-Vascular Lesions, at the Melbourne Hospital.  
2.15 p.m.—DR. R. R. WETTENHALL: Demonstration of Dermatological Cases, at the Melbourne Hospital.

##### Wednesday, November 19, 1924.

- 9.30 a.m.—DR. A. WILSON: "Birth Injuries," at the Women's Hospital.  
11.15 a.m.—DR. J. GREEN: "Cause and Prevention of Still-Birth," at the Women's Hospital.



2.15 p.m.—MR. A. NEWTON: Demonstration of the Surgical Anatomy of the Axilla, Neck, Stomach, Hernia and So Forth," at the Anatomy School, University of Melbourne.

#### Thursday, November 20, 1924.

9.30 a.m.—DR. H. TURNBULL: "Significance and Treatment of Heart Failure," at the Melbourne Hospital.

MR. W. G. DISMORE UPJOHN: "Injuries to the Hip and Shoulder," at the Melbourne Hospital.

11.15 a.m.—DR. W. W. S. JOHNSTON: "Nephritis: Diagnosis and Prognosis," at the Melbourne Hospital.

DR. B. ZWAR: "Empyema in the Adult," at the Melbourne Hospital.

2.15 p.m.—DR. F. SCHOLES: Demonstration of Cases of Infectious Disease at the Hospital for Infectious Diseases, Fairfield.

8 p.m.—DR. M. F. H. GAMBLE: "Certification of Cases of Insanity," at the Alfred Hospital.

#### Friday, November 21, 1924.

9.30 a.m.—MR. B. QUICK: "Operation for Acute Appendicitis," at the Alfred Hospital.

DR. M. D. SILBERBERG: "Chronic Myocardial Degeneration," at the Alfred Hospital.

11.15 a.m.—MR. R. ST. C. STEUART: "Common Orthopaedic Conditions," at the Alfred Hospital.

DR. W. SUMMONS: "Rheumatoid Arthritis and Protein Therapy," at the Alfred Hospital.

2.15 p.m.—DR. H. D. STEPHENS: "Paralysis in Children," at the Children's Hospital.

8 p.m.—DR. R. WEBSTER: "Bacillary Dysentery in Children," at the Children's Hospital.

### Correspondence.

#### MALIGNANT DISEASE OF THE UTERUS.

SIR: In your issue of September 20, 1924, Dr. J. K. Couch in his article on "Malignant Disease of the Uterus" sums up:

In conclusion, gentlemen, a hysterectomy properly done when the disease can be removed with the minimum risk to the bladder, ureter or rectum is the only treatment worth a moment's consideration in this distressing and hopeless disease. . . . In hopeless cases the hypodermic syringe and not the scalpel should be used and used boldly too.

It seems difficult to understand how the extensive experience of leading gynecologists in the chief clinics abroad as recorded in the voluminous literature upon this subject should be so entirely ignored by the complete absence of any reference to radium and X-ray treatment. It is of course too extensive a subject to discuss in a letter, but I need only refer for instance to an article, "Relative Values of Irradiation and Radical Hysterectomy for Cancer of the Cervix," by J. G. Clark and F. B. Block, in the May, 1924, number of the *American Journal of Obstetrics and Gynecology*, pages 543-550, for a very critical study based on experiences of the best known workers in America and Europe, comparing the results as judged by the five year standard of cure. Many of those reaching this standard were previously classed as inoperable.

Even those whom it is not expected to cure, the amount of palliation given by radio-therapy is so manifestly superior to that of every other method of treatment, that irradiation is always worth while employing, provided the patient is not too cachectic or is not moribund.

The limited experience of this class of work seen and reported in Australia tends in large measure to confirm the published results abroad.

Yours, etc.,

Harley House, 71, Collins Street,  
Melbourne,  
September 25, 1924.

H. FLECKER.

#### CAUSES OF DEPOPULATION AMONG SOME ISLAND PEOPLES.

SIR: IN THE MEDICAL JOURNAL OF AUSTRALIA, Volume I, of January 19, 1924, there appeared a paper by Dr. J. H. S. Jackson, of Kavieng, Mandated Territory of New Guinea, entitled "Causes of Depopulation Among Some Island Peoples."

In 1919 I submitted to this Administration a report on the same subject at the request of the then Administrator, Brigadier-General G. Johnston. Dr. Jackson confirmed the whole of my findings with regard to the causes of depopulation with the exception of my figures in respect of syphilis and gonorrhoea. My own statement was that there was much to be said for the common statement that all natives in Kavieng have had or will have gonorrhoea. Dr. Jackson stated that in over nine thousand examinations gonorrhoea was found ten times.

When I took over shortly afterwards the position of Acting Director of Public Health to this Territory, I requested Dr. Jackson to make an examination of all at his head station, Kavieng, and of the natives in an immediate radius of ten miles, checking the population by the census book. Dr. Jackson's first cursory examination revealed amongst this small section of the population one hundred and eighty-seven cases of gonorrhoea. At the date of writing, Dr. Jackson reports that there are now over three hundred natives in hospital suffering with the disease and that it appears to be very widespread.

As explanation of the discrepancy Dr. Jackson says that the chief danger is amongst indentured labour and not amongst natives. Further investigation, however, has revealed that the villages themselves are very considerably infected.

Yours, etc.,

R. W. CILENTO, M.D., B.S., D.T.M. & H.

Rabaul,

September 24, 1924.

#### THE PREPARATION OF "CARBONIC SNOW."

SIR: I should be much obliged if any readers of THE MEDICAL JOURNAL OF AUSTRALIA could explain the vagaries in the formation of "carbonic snow." I have readily obtained the "snow" from a cylinder of carbonic acid gas by tying chamois leather over the outlet and allowing the gas to flow. At other times the "snow" would not form, though the same method was tried. What is the reason and how can it be formed with reasonable certainty? Is it due to impure gas, too great or too little pressure or atmospheric conditions?

Yours, etc.,

B. B. ARMSTRONG, M.B., B.S.

Kent Street, Maffra, Victoria,

October 8, 1924.

"Carbonic snow," that is carbon dioxide in semi-solid state, forms readily when the carbon dioxide is liberated from a cylinder at a pressure of sixty-five atmospheres. The carbon dioxide escapes in liquid form at a temperature of  $-79^{\circ}\text{C}$ . If the pressure is too low or if the cock is not opened sufficiently, gas and not liquid flows from the cylinder and "snow" does not form. The "snow" is best collected in a tubular arrangement. A useful method is to wrap a towel folder four times around a ruler and to withdraw the ruler, leaving the tubular towel as container. Dr. Armstrong's difficulty has probably been caused by the carbon dioxide in the cylinder not being under a sufficiently heavy pressure.—EDITOR.]

#### SPECIALISTS AND THE GENTLE ART OF MONEY MAKING: GET-RICH-QUICK-WALLINGFORD HAS COMPEERS.

SIR: I sent an aged patient with an ulceration of scalp to a specialist in Melbourne for his opinion *et cetera*. He was accompanied by his grandson, a young medical practitioner.



On his return from his pilgrimage the patient told me the specialist advised him to see a certain surgeon to ascertain the advisability of operation, to have his blood tested, to have an X-ray examination and to be treated in a certain way, if it could be done in Geelong. He agreed duly to all this with the exception of the X-ray examination. The specialist said he would write to me and let me know his opinion. On September 27 the patient paid his account and on September 30 I received the specialist's letter dated September 29. Subjoined is the receipted account.

Mr. Patient,

With Dr. Specialist's compliments.

Professional fees to date are:

Consultation with Dr. Grandson ..	£2	2	0
Consultation with Dr. Surgeon ..	2	2	0
Blood test .. .. .	2	2	0
Letter Dr. Newman .. .. .	2	2	0
	£8	8	0

With your permission I may be able to give further examples of modern medical and surgical methods.

Yours, etc.,

F. J. NEWMAN.

Kooyong, Geelong,

October 10, 1924.

#### PUERPERAL MORTALITY.

Sir: In view of the discussion which is taking place throughout Australia on the subject of puerperal mortality, the following extract may be of service. It is taken from the report of the Commission appointed by the Rockefeller Foundation to inquire into the training and utility of the nursing profession.

##### Reduction of Maternal Mortality.

The results achieved by pre-natal nursing have been so promising that during the past few years a considerable extension of this work has taken place.

Thus, for instance, in Boston the pre-natal nursing of the Instructive Visiting Nurse Association reduced the maternal death rate for the year 1920 from seven in every thousand births to two in every thousand births.

In Cleveland a study of the records of four hundred and forty-two mothers receiving excellent pre-natal care in a district of the city with highly unfavourable social and economic conditions showed a reduction in the maternal death rate from four per thousand births for the city as a whole to 1.4 per thousand births.

The Metropolitan Life Insurance Company, whose nursing services for its policy holders are described in a later section (page 52), reports that during the period from 1911 to 1919, among women between the ages of 25 and 44, whom the nursing service especially served in maternity care the mortality rate was reduced 20.5%, while among women of these ages in the population as a whole, the reduction for the same period was 3.8%.

The remarkable growth of the pre-natal work carried on by twelve privately supported visiting nurse associations with whom the Metropolitan Life Insurance Company has working agreements for nursing its policy holders, is shown in a recent unpublished study by the company. Between 1915 and 1920 the percentage of cases given pre-natal as well as post-natal care, of the total maternity cases visited by these twelve associations, increased fivefold, from 8% to 41%. The duration of such care increased more than two and one-half times, from 26.3 to 64.2 days in 1920.

Yours, etc.,

JAMES W. BARRETT.

105, Collins Street,  
Melbourne, October 23, 1924.

#### Obituary.

JOHN STEELL.

It is with regret that we announce the death of Dr. John Steell which occurred at Ringwood, Victoria, on October 6, 1924.

John Steell came of a well known Scottish family and went to Edinburgh for his education. In 1882 he was admitted as licentiate of the Royal College of Surgeons and of Physicians of Edinburgh and obtained the degrees of bachelor of medicine and master of surgery at Edinburgh University in the following year.

After having had some experience as clinical assistant at the Royal Asylum, Morningside, he came to Australia and was appointed in 1890 in a temporary position to the medical staff at the Kew Hospital for Insane. The following year he was permanently appointed to the position of junior medical officer at the Hospital for Insane, Ararat. After having held various other positions he was appointed medical superintendent of the Ballarat Asylum in 1901. Nine years later he was transferred to the charge of the Yarra Bend Asylum. He left the department on superannuation in 1922.

John Steell was of a kindly and genial nature; he was well liked by his patients and was respected by his staff. He took a great interest in military work and attained the rank of lieutenant-colonel in the Australian Army Medical Corps. During the war he was busily engaged in the examination of recruits and took an active part in the inception of the Base Hospital in St. Kilda Road, Melbourne. He leaves a widow who has the respectful sympathies of a very large number of friends.

WILLIAM HENRY SEMPLE.

We regret to announce the death of Dr. William Henry Semple, of Kilmore, Victoria. Dr. Semple was in his eighty-fifth year and was a practitioner of sixty years' standing. His death took place in Kilmore on October 3, 1924.

GEORGE HENRY GIBSON.

It is with much regret that we learn of the death on October 11, 1924, of Dr. George Henry Gibson, of Hobart.

#### ANDERSON STUART RESEARCH MEMORIAL FUND.

We have been requested by the Committee of the Anderson Stuart Research Memorial Fund to announce that since the publication of the list of subscriptions in our issue of September 20, 1924, further contributions have been received as follows: Professor F. P. Sandes, £100; Professor H. G. Chapman, £100; Dr. F. A. Maguire, D.S.O., £21 and Dr. F. Antill Pockley (to bring the total to a round figure), £3 7s. 6d. At the final meeting of the Committee on October 13, 1924, it was resolved to ask the Senate of the University of Sydney to accept the fund amounting to £1,400 for the purpose of establishing a research scholarship in medicine to be called the Anderson Stuart Research Scholarship.

#### University Intelligence.

THE UNIVERSITY OF SYDNEY.

EARLIER in the year a strong committee of the University of Sydney was appointed for the purpose of establishing a Sydney University War Memorial Carillon. The objective of the committee was to raise the sum of £15,000 to secure a set of forty-nine bells, ranging in price from £21 to £1,500. In the course of time many of the individual bells were bought as special memorials. The third largest bell was still available until quite recently. In order that this bell might be taken by the medical profession, the contributions of the New South Wales Branch of the British Medical Association and those of the Faculty of Medicine of the University were pooled and a certain sum was advanced privately to bring the amount up to £1,070, the



price of the bell. It will be a magnificent permanent memorial to those medical graduates and undergraduates of the Sydney University who served and fell in the Great War. The medical profession in the State is to be congratulated on being associated with this fine movement.

### Congress Notes.

#### INTERNATIONAL CONGRESS OF RADIOLOGY.

It has been suggested that an International Congress of Radiology shall be held in London in the summer of 1925. The date proposed for the opening is June 30 and the Congress will occupy four days of two sessions each. Subsequent visits will be made to provincial centres. The house of the British Institute of Radiology will be used as an administrative and social centre for the Congress. The date of the Congress will be definitely fixed at a meeting to be held in London in September of this year. Dr. J. E. A. Lynham and Dr. John Muir are the joint secretaries. All communications should be addressed to the secretaries at the British Institute of Radiology, 32, Welbeck Street, London, W.1.

### Books Received.

- FACIAL SURGERY, by H. P. Pickerill, C.B.E., M.D., M.S., with an Introduction by Sir W. Arbuthnot Lane, Bart., C.B., M.S.; 1924. Edinburgh: E. and S. Livingstone; Crown 4to., pp. 162, with illustrations. Price: 21s. net.
- REPORT ON THE INVESTIGATION OF A NUMBER OF CASES OF LEPROSY AT NAURU, CENTRAL PACIFIC, by F. G. Morgan, M.B., B.S.; 1924. Melbourne: Issued by The Commonwealth Department of Health. Royal 8vo., pp. 25.
- SEVEN COMMON SPECIES OF MOSQUITOES: DESCRIBED FOR PURPOSES OF IDENTIFICATION, by L. E. Cooling, Entomologist; 1924. Melbourne: Issued by The Division of Tropical Hygiene of the Commonwealth Department of Health; Royal 8vo., pp. 24.
- SMALL SEWAGE TANKS, issued by The Division of Sanitary Engineering of the Commonwealth Department of Health; 1924. Melbourne. Royal 8vo., pp. 22.

### Medical Appointments.

DR. E. S. MORRIS (B.M.A.), Director of Public Health, Tasmania, has been appointed a member of the Supply and Tender Board, Tasmania.

DR. CLARENCE G. GODFREY (B.M.A.) has been appointed Deputy Inspector-General of the Insane, Victoria, during the absence on leave of DR. W. E. JONES.

DR. ALBERT CURTIS (B.M.A.) has been appointed Medical Superintendent of the Hospital for the Insane and the Receiving House, Ballarat, Victoria, during the absence of DR. PATRICK SHAW.

DR. RICHARD ARTHUR (B.M.A.), M.L.A., has been appointed Government Nominee on the Board of Directors of the Sydney Hospital.

DR. REGINALD EDWARD NOWLAND (B.M.A.) has been appointed Government Medical Officer at Wyong, New South Wales.

### Medical Appointments Vacant, etc..

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xvi.

ALFRED HOSPITAL, MELBOURNE: Out-Patient Physician.  
SYDNEY HOSPITAL, SYDNEY: Honorary Assistant Gynaecological Surgeon.

THE UNIVERSITY OF MELBOURNE: Lectureship in Obstetrics and Gynaecology.

### Medical Appointments: Important Notice.

MEDICAL practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429, Strand, London, W.C..

BRANCH.	APPOINTMENTS.
NEW SOUTH WALES: Honorary Secretary, 30 - 34, Elizabeth Street, Sydney.	Australian Natives' Association. Ashfield and District Friendly Societies' Dispensary. Balmain United Friendly Societies' Dispensary. Friendly Society Lodges at Casino. Leichhardt and Petersham Dispensary. Manchester Unity Oddfellows' Medical Institute, Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. North Sydney United Friendly Societies. People's Prudential Benefit Society. Phoenix Mutual Provident Society.
VICTORIAN: Honorary Secretary, Medical Society Hall, East Melbourne.	All Institutes or Medical Dispensaries. Australian Prudential Association Proprietary, Limited. Mutual National Provident Club. National Provident Association.
QUEENSLAND: Hon- orary Secretary, B. M. A. Building, Adelaide Street, Brisbane.	Brisbane United Friendly Society Institute. Stannary Hills Hospital.
SOUTH AUSTRALIAN: Honorary Secretary, 12, North Terrace, Adelaide.	Contract Practice Appointments at Renmark. Contract Practice Appointments in South Australia.
WESTERN AUS- TRALIAN: Honorary Secretary, Saint George's Terrace, Perth.	All Contract Practice Appointments in Western Australia.
NEW ZEALAND (WELLINGTON DIVI- SION): Honorary Secretary, Wellin- gton.	Friendly Society Lodges, Wellington, New Zealand.

### Diary for the Month.

- Nov. 7.—Queensland Branch, B.M.A.: Branch.  
Nov. 11.—New South Wales Branch, B.M.A.: Ethics Committee.  
Nov. 12.—Tasmanian Branch, B.M.A.: Branch.  
Nov. 12.—Victorian Branch, B.M.A.: Late date of Nomination  
of Council. Election of Scrutineers.  
Nov. 12.—Central Northern Medical Association, New South  
Wales.  
Nov. 12.—Melbourne Paediatric Society.  
Nov. 13.—New South Wales Branch, B.M.A.: Clinical Meeting.  
Nov. 13.—Victorian Branch, B.M.A.: Council. Nomination by  
Victorian Branch of Representative of Group on  
Council, London.  
Nov. 13.—South Australian Branch, B.M.A.: Council.  
Nov. 13.—Brisbane Hospital for Sick Children. Clinical  
Meeting.  
Nov. 14.—Queensland Branch, B.M.A.: Council.  
Nov. 18.—New South Wales Branch, B.M.A.: Executive and  
Finance Committee. Illawarra Suburbs Medical  
Association (Annual).  
Nov. 19.—Western Australian Branch, B.M.A.: Branch.  
Nov. 25.—New South Wales Branch, B.M.A.: Medical Politics  
Committee. Organization and Science Committee.  
Nov. 26.—Victorian Branch, B.M.A.: Council.  
Nov. 27.—New South Wales Branch, B.M.A.: Branch.

### Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to "The Editor," THE MEDICAL JOURNAL OF AUSTRALIA, B.M.A. Building, 30-34, Elizabeth Street, Sydney. (Telephone: B. 4635.)

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